Other Coverage Questionnaire – Dependent Child(ren)

Employer's Name: _____

Employee's Name: _____

Child's Name: _____

Child's marital status: ☐ Single ☐ Married
If married, spouse's name: _____
If married, spouse's date of birth: _____
If married, spouse's employer's name: _____

Is the child attending school? ☐ Yes ☐ No If yes, complete the school information below:
Name of School: _____
Type of School: ☐ High School ☐ College/Trade
Student Status: ☐ Full-time ☐ Part-time
Expected Graduation Date: _____

Is the child covered under any of the following health plans?
☐ Other biological parent's plan ☐ Step parent's plan ☐ No other coverage
☐ Medicare ☐ Medicaid ☐ Tricare
☐ Child's own employer plan ☐ Child's spouse's plan ☐ State plan/CHIP

Is there a divorce decree involved? ☐ Yes ☐ No (Attach Copy if applicable)
Spouse / other parents date of birth: _____

If this dependent has health coverage through another source, please complete the following information:

Name of Insured (Policy Holder)	Date of Birth of Policy Holder	Employer	Insurance Carrier	Effective date of Coverage	Med	Den	Vis

To the Employee: I understand that falsifying employment status and/or coverages is fraud and could result in financial penalty, loss of coverage, and separation of employment.

_____ _____
Employee's Signature Date

_____ _____
Child's Signature (if age 18 or older) Date

Return completed form to: Dunn & Associates
Mail: PO Box 2369 Columbus, IN 47202-2369 – Fax (812) 378-9967 – Email: eligibility@dunnbenefit.com

***Dependent child's employer must complete this page.**

***To the employer: Any person who with intent to fraud or facilitate a fraud or provide false information, may be guilty of insurance fraud.**

DUNN & Associates
Benefit ▪ Administrators ▪ Inc.

Dependent child's name: _____

1. Do you offer insurance benefits/coverage to your employees? ☐ Yes ☐ No

2. Is the above-mentioned child (your employee) eligible for benefits/coverage? ☐ Yes ☐ No

3. If they are eligible for benefits/coverage, what is the first date eligible: _____

3. What coverage(s) are he/she eligible for? ☐ Medical/Drug ☐ Dental ☐ Vision

4. What coverage(s) did he/she elect? ☐ Medical/Drug ☐ Dental ☐ Vision

5. If coverages were elected, what is the effective date of coverage under your plan? _____

Name of Employer: _____

Employer's Phone #: _____

Employer Representative Title: _____

Employer Representative Email: _____

Employer Representative Name (printed): _____

Employer Representative Name (signature): _____

Date: _____

Dependent child/your employee's signature: _____

Date: _____

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