

SECTION III – OTHER COVERAGE

<p>Part A: Spouse (If Applicable)</p> <p>Does your spouse have any other health coverage?</p> <p><input type="checkbox"/> No other coverage <input type="checkbox"/> Single coverage <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family Coverage</p>	<p>Name and Location of Spouse's Employer: My Spouse's employer: <input type="checkbox"/> does <input type="checkbox"/> Does not offer health coverage</p> <p>If family coverage is in place through your spouse's employer, please specify which children listed on page 1 are covered under his/her plan and what type of coverage exists:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Name of Child</th> <th style="width:33%;">Name of Child</th> <th style="width:33%;">Type of Coverage</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Medical</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Dental</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Prescription Drug</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Vision</td> </tr> </tbody> </table>	Name of Child	Name of Child	Type of Coverage	_____	_____	<input type="checkbox"/> Medical	_____	_____	<input type="checkbox"/> Dental	_____	_____	<input type="checkbox"/> Prescription Drug	_____	_____	<input type="checkbox"/> Vision
Name of Child	Name of Child	Type of Coverage														
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_____	_____	<input type="checkbox"/> Dental														
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_____	_____	<input type="checkbox"/> Vision														

<p>Part B: Ex-Spouse (If Applicable)</p> <p>Does your ex-spouse have any other health coverage?</p> <p><input type="checkbox"/> No other coverage <input type="checkbox"/> Single coverage <input type="checkbox"/> Family Coverage</p> <p>Ex-Spouse's Address: _____</p>	<p>Name: _____ SSN: (if available) _____ My Ex-Spouse's employer: <input type="checkbox"/> does <input type="checkbox"/> does not offer health coverage</p> <p>If family coverage is in place through your ex-spouse's employer, please specify which children listed on page 1 are covered under his/her plan, what type of coverage exists, and the name and address of the health plan:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Name of Child</th> <th style="width:33%;">Name of Child</th> <th style="width:33%;">Type of Coverage</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Medical</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Dental</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Prescription Drug</td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> Vision</td> </tr> </tbody> </table> <p>Name and Address of Health Care Plan: _____</p>	Name of Child	Name of Child	Type of Coverage	_____	_____	<input type="checkbox"/> Medical	_____	_____	<input type="checkbox"/> Dental	_____	_____	<input type="checkbox"/> Prescription Drug	_____	_____	<input type="checkbox"/> Vision
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_____	_____	<input type="checkbox"/> Vision														

SECTION IV – LEGAL PROVISIONS (If Applicable)

Are all of the children listed on page 1 dependent upon you for support and maintenance?
 Yes No If No, list who is not: _____

Will you claim all the dependents listed on Page 1 on this year's income tax return?
 Yes No If No, list those who will not be claimed: _____

Do all the dependents listed on Page 1 reside with you more than six months per year? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list the dependents here and indicate your custody arrangement →	Dependent Name	Joint custody-less than 6 months per year	Visitation Rights	No Contact

Does a divorce decree or court order make provision as to who is responsible for health insurance or tax exemptions for the dependent children listed on page 1?
 Yes No *If Yes, please provide a copy of the section of the divorce decree or court order relating to tax exemptions and insurance. This information is required to verify dependent eligibility for your health plan. Note: if you have previously submitted the decree or court order please disregard this request.*

SECTION V -- SIGNATURE *(After filling in both sides of this form as completely as possible, please sign BOTH signature lines below.)*

To the best of my knowledge, the above is complete and true, and I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage and/or refuse payment of claims. **Updates or additions to this information may be required periodically.**

 Sign your name Date Completed

DO NOT PRINT OR TYPE

By signing below, I authorize all physicians, Ph.D.s, hospitals, druggists, and all agencies including other claim administrators to furnish to Self Insured Services Company (SISCO), HEALTHCORP, and the health plan full information pertaining to the diagnosis and treatment of medical, mental health, and drug and alcohol conditions. I understand that the purpose or need for this disclosure is to verify eligibility of benefits. I also understand that this consent is subject to revocation at any time through a written submission to SISCO.

 Employee's Signature Date

 Spouse's Signature Date

Complete Both Sides of This Form →