Other Coverage Questionnaire – Dependent Child(ren)

Your employer's plan requires you to provide information regarding other coverage on your dependent children. Failure to provide accurate and current information on changes throughout the year may be considered insurance fraud. If any of the information below changes, please contact HR immediately.

Employer's Name: _____

Employee's Name: _____

Child(ren) Name: _____

Is the child covered under any of the following health plans? ☐ No other coverage

☐ Other biological parent's plan ☐ Step parent's plan ☐ State plan/CHIP
☐ Medicare ☐ Medicaid ☐ Tricare

Working age children/married children:

☐ Child's own employer plan ☐ Child's spouse's plan

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

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

Name of Dependent	Name of Policy Holder	Policy Holder (Date of Birth	Insurance Carrier	Effective date of Coverage **REQUIRED** (MM/DD/YYYY)	Med	Den	Vis

To the Employee: I understand that falsifying employment status and/or coverages is fraud and could result in financial penalties, 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. What coverage(s) did he/she elect? ☐ Medical/Drug ☐ Dental ☐ Vision

2. 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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