



Dependent Addition and Change Form For Court-Mandated Health Coverage Complete In Ink Please Print

☐ Addition ☐ Change (see reverse side)

Form with fields for Group No., Section No., Member Identification No. (Medical), Member Identification No. (Dental), Payroll No., Employee's Last Name (First, Middle), Home Address No. and Street Name, City, State, ZIP, Phone No., Custodial Parent's Last Name (First, Middle), Home Address No. and Street Name, City, State, ZIP, Phone No., State Agency Name, Agency No., Date Employer Received Order, Phone No., State Agency Address No. and Street Name, City, State, ZIP.

Complete all information for each dependent being added. Effective 1-1-96: Health care companies in Texas are required to follow special procedures in situations where a natural or adoptive parent (or legal guardian) is required by a court to provide health coverage for a child. A Copy of the Court or Administrative Order or Decree Must Accompany This Form.

Table with 6 columns: List the Full Name of All Dependents To Be Covered (Last, First, Middle), Social Security No., Date of Birth (Mo/Day/Yr), PCP/PCD Name (HMO only), PCP/PCD#, Are You a New Patient? (Yes/No). Includes checkboxes for Son/Daughter.

Previous Coverage Information Complete only if applying for coverage other than HMO or In-Hospital Indemnity. In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.) If Medicare, please complete the Medicare coverage Information Section below. List names of every individual covered:

Form with fields for Primary Enrollee (Name, Date of Birth, Male/Female, Relationship to Applicant, Group or Policy Number, ID Number), Employer's Name, Employment Date, Effective Date, Will coverage be continued? (Yes/No), If No, Expected Cancel Date, Type of Coverage (Health/Dental), Type of Policy (Self/Family/Employee/Spouse/Employee/Child).

Are any of the above dependents covered by any other health or dental coverage? ☐ Yes ☐ No If yes, please check the applicable boxes below and list the effective date for each coverage checked and complete the remainder of this section. ☐ Health ☐ Dental ☐ Group ☐ Individual ☐ Medicare Part A (Hospital) Eff. ___/___/___ ☐ Medicare Part B (Medical) Eff. ___/___/___ Please check the reason for Medicare eligibility: ☐ Entitled Disability ☐ End Stage Renal Disease ☐ Disability and Current Renal Disease

Form with fields for Name and Address of Other Health Care Co., ID/Medicare Number, Group or Policy No., Employer's Name, Name of Primary Enrollee, Date of Birth, Male/Female, Relationship To Applicant (Spouse/Dependent).

As a supplement to my previous Application, I request the change(s) in coverage to include dependents listed above.

____ X _____ Date Signature Relation to Dependent

Home Phone Number (_____) _____



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Form with fields for Group No., Section, Member Identification No. (Medical), Member Identification No. (Dental), Payroll No., Employee's Last Name, First, Middle, Home Address No. and Street Name, City, State, ZIP, Phone No., Custodial Parent's Last Name, First, Middle, Home Address No. and Street Name, City, State, ZIP, Phone No., State Agency Name, Agency No., Phone No., State Agency Address No. and Street Name, City, State, ZIP.

Complete all information for the change to each existing dependent

Please check the applicable box(es), show date:

- Cancel dependent coverage, Change of Address - listed above, Deceased, Married, PCP/PCD Change, Other

Table with 6 columns: List The Full Name of All Dependents To Be Covered (Last, First, Middle), Social Security No., Date of Birth (Mo /Day/Yr), PCP/PCD Name, PCP/PCD#, Are You a New Patient? (Yes/No). Includes checkboxes for Son/Daughter.

As a supplement to my previous Application, I request the change(s) in coverage to include dependents listed above.

Date X Signature Relation to Dependent

Home Phone Number ()