

NORTH AMERICA ADMINISTRATORS, L.P. - DEPENDENT INFORMATION & INSURANCE VERIFICATION FORM

This form is to be completed by the Employee. Please complete only the Section that applies. Please complete a separate form for each Dependent.

Return to: NAA - Eligibility Dept.
 P O Box 1984
 Nashville, TN 37202
 Phone: 615-256-3561; Toll Free: 800-411-3650
 Fax: 615-255-6654

Use a separate sheet or the back of this form, if necessary.

EMPLOYER: _____ Employee: _____ SSN: _____
 Dependent Name: _____ Date of Birth: _____ Dependent SSN: _____
 Sex: _____ Relationship to Employee: **(CHECK ONE)** Natural Child Adopted Child Step-Child Other _____

1. If Natural Child or Adopted Child:

Did this child have any other medical coverage in the past 18 months? [] YES [] NO
 If YES, provide a copy of the Certificate of Creditable Coverage.

Is the child dependent upon you for principal support (more than 50%)? [] YES [] NO

Is the child employed full-time? [] YES [] NO

Does the child reside in your home for more than six (6) months a year? [] YES [] NO

If NO, explain: _____

Do you have full time care and custody of the child? [] YES [] NO

If NO, explain: _____

If YES, does this child have any other medical coverage currently in force? [] YES [] NO
 If YES, provide the following information for the other insurance carrier or plan and provide a copy of that insurance card:

Name/Address _____
 Policy/Group No. _____ Telephone No. _____

Is there a document of any kind that requires you or any other person to maintain health coverage for this child? [] YES [] NO
If YES, a copy of the document MUST be returned with this form. If NO, please provide a copy of the birth certificate.

2. If Step-Child:

Please provide a copy of spouse's Divorce Decree or QMCSO.

Did this child have any other medical coverage in the past 18 months? [] YES [] NO
 If YES, provide a copy of the Certificate of Creditable Coverage.

Can you claim this child for federal income tax purposes? [] YES [] NO

Is the child employed full-time? [] YES [] NO

Does the child reside in your home? [] YES [] NO

If NO, explain: _____

Do you regularly provide more than one-half of the financial support of this child? [] YES [] NO

If NO, explain: _____

Does this child have any other medical coverage currently in force? [] YES [] NO
 If YES, provide the following information for the other insurance carrier or plan and provide a copy of that insurance card:

Name/Address _____
 Policy/Group No. _____ Telephone No. _____

3. If Other:

Did this individual have any other medical coverage in the past 18 months? [] YES [] NO
 If YES, provide a copy of the Certificate of Creditable Coverage.

Can you claim this individual for federal income tax purposes? [] YES [] NO

Is this individual employed full-time? [] YES [] NO

Do you regularly provide more than one-half of the financial support? [] YES [] NO

If NO, explain: _____

Does this individual have any other medical coverage currently in force? [] YES [] NO
 If YES, provide the following information for the other insurance carrier or plan and provide a copy of that insurance card:

Name/Address _____
 Policy/Group No. _____ Telephone No. _____

Does this individual reside in your home? [] YES [] NO
 If NO, explain: _____

I hereby certify that the above statements are true and complete to the best of my knowledge and I realize that failure to provide accurate information may cause a loss of benefits.

Employee Signature

Date