HEALTH INSURANCE INFORMATION

DCSS 0054 (04/27/2005)

County: Phone: 866-901-3212 LCSA Case Number:

Noncustodial Parent:

Full Name (First, Middle, Last, Suffix)	I am the ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer
Address (Street)	City, State, Zip Code
Phone	Social Security Number

Employer (Name, street, city, state, zip code, phone)

INSTRUCTIONS: Please complete SECTION I if health insurance is provided or available by the Noncustodial Parent or employer. SECTION II is about the other parent's insurance. Employers complete Sections I and III only. Please sign and date the completed form.

SECTION I: YOUR HEALTH INSURANCE

HEALTH INSURANCE:

Do you currently have Health Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Health Insurance Company or Union (provide Union Local number)	Provided by: ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer ☐ Other: Relationship:
Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)	Telephone Number (*include Area Code)*
City State Zip Code	Policy Number
Premium Amount $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of Health Insurance $ / Cost to add additional child $

Dependent(s) Currently Covered By Health Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Health Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

The Policy covers the following: (Check all that apply)

☐ Doctor Visits ☐ Medicare Supplemental ☐ Specific Illness ☐ Prescription Drugs

☐ Long Term Care ☐ Hospital Stays ☐ Hospital Outpatient *(i.e., lab work, physical therapy)* ☐ Other (Specify):

DENTAL INSURANCE:

Do you currently have Dental Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (a*ddress where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Dental Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Dental Insurance are listed on a separate sheet of paper. Please attach the sheet.

☐ Not available to dependents

VISION INSURANCE:

Do you currently have Vision Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Vision Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Vision Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

SECTION II: OTHER PARENT'S INSURANCE

HEALTH INSURANCE:
Does the other parent currently provide Health Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Health Insurance Company

Health insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

DENTAL INSURANCE:
Does the other parent currently provide Dental Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

VISION INSURANCE:
Does the other parent currently provide Vision Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

SECTION III: (MUST BE COMPLETED)

☐ I have enclosed the insurance card(s)/information about the coverage for the child(ren).

☐ At this time I do not have the insurance cards/information about the coverage for the child(ren). I will send the information to you when I get it from the insurance company.

☐ At this time there is no health insurance coverage available. I understand that if it becomes available, I will have to add my child(ren) onto the plan and then notify the local child support agency of the coverage. Coverage is unavailable because:

☐ Not offered ☐ Seasonal ☐ Part-Time ☐ Refused enrollment ☐ Unreasonable in cost ☐ Probationary period/date eligible

PRIVACY STATEMENT

The information Practices Act of 1997 (Civil Code Section 1798.17) and the Federal Privacy Act of 1974 (Public Law 93-579) require this notice be provided when collecting personal information from individuals. Information requested on this form, including Social Security Number, is used by the Department of Child Support Services (DCSS) for purposes of identification and communication with you. The DCSS is required, under Section 466 (a)(13) of the Social Security Act, to collect the Social Security Number of any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgement.

Social Security Number information is mandatory and will be kept on file at the local child support agency to locate and identify individuals and assets for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent.

The information in your case may be discussed with or given to the State, other agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law.

SIGNATURE DATE

PRINTED NAME TELEPHONE (include Area Code)

TITLE