

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: _____ Your State ID number, if any: _____

Do you, your children or others in your home have health insurance coverage? Yes No, then stop here.

If yes, who carries this health insurance?

- You A parent who does not live with you
 Someone else in your home Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

- Major Medical Drug Medicare Supplement
 Dental Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ()
Mailing address (House #, Street, Apt, <i>OR</i> PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ()
Insurance claims office mailing address (#, Street, <i>OR</i> PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One:		Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	Add	Drop					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					

Information About Second Policy

Choose **all** that apply to this policy:

Major Medical

Drug

Medicare Supplement

Dental

Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ()
Mailing address (House #, Street, Apt, OR PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ()
Insurance claims office mailing address (#, Street, OR PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
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People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One:		Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	Add	Drop					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

For office use only:

County # _____

Worker # _____

Date Rec'd _____