

Iowa Department of Human Services
EMPLOYER HEALTH INSURANCE QUESTIONNAIRE

«VAR3»
«VAR5»
«VAR6»
«VAR7»

Date Prepared: «VAR1»
Case Number: «VAR2»
«VAR4»

SSN: «VAR8»
Employee Name: «VAR9»

Dear Employer:

Federal regulations (45 CFR 303.30) require that we obtain health insurance information about the above-named employee's dependents. Our information indicates this person is currently employed by you. Please provide the following information regarding employment and health benefits available to your employee.

Employment Information:

Name of employee: _____ DOB: ____ / ____ / ____

Current or last known home address: _____

Employee's rate of pay:

Hourly: Wage _____, hours per pay period _____, frequency of pay _____.

Salary: Salary _____ per _____ (how often paid).

Does the employee work overtime on a regular basis? _____ If yes, what is the usual pay and frequency of this? _____ per _____.

Is there a mandatory pension plan? _____ If yes, list the amount deducted _____ and frequency _____.

If the above mentioned person is no longer employed with you, please provide the date of termination and the name and address of this person's current employer.

Date: ____ / ____ / ____ . _____

Health Insurance Information:

Does your company offer a health benefit plan which would cover the dependents of the above-named employee? Yes No Date available _____

Is the employee enrolled? Yes No Effective date of policy: ____ / ____ / ____

Are the dependents of the above-named employee enrolled? Yes No

What is the cost of the dependent health insurance premium per month? _____ If the dependents are enrolled, please complete the following:

	Insurer #1	Insurer #2
Name of Insurer	_____	_____
Address	_____ _____	_____ _____
Claims Filed With	_____	_____
Address	_____ _____	_____ _____

Dependent Name	Policy Numbers	Effective Date	Policy Numbers	Effective Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Types of Coverage
Insurer #1

- Ambulance
- Hospital
- Physician
- Dental
- Lab & X-Ray
- Spec Disease - Cancer
- Drugs
- Medical Equipment
- Spec Disease - Heart
- Home Health Agency
- Nursing Home - Inter
- Vision
- Hospice
- Nursing Home - Skill

Source Information

- Accident Policy
- Medicaid Trust
- CHAMPUS
- Medicare - Part A Only
- CHAMPVA
- Medicare - Part B Only
- Indemnity Policy
- Medicare - Part A & B
- Major Medical
- Veterans Admin

Types of Coverage
Insurer #2

- Ambulance
- Hospital
- Physician
- Dental
- Lab & X-Ray
- Spec Disease - Cancer
- Drugs
- Medical Equipment
- Spec Disease - Heart
- Home Health Agency
- Nursing Home - Inter
- Vision
- Hospice
- Nursing Home – Skill

Source Information

- Accident Policy
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- Medicare - Part A & B
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If there are additional carriers or coverage, please provide an attachment. If this employee's health insurance coverage should lapse or change for any of the above-named dependents, please notify the Child Support Recovery Unit (CSRU) within ten (10) days at the address listed below.

Signature of person completing form: _____

To return this questionnaire, fold so that the address listed below appears in the window of the return envelope provided.

Child Support Recovery Unit
«VAR10» «VAR11»
«VAR12»
«VAR13»
«VAR14»