

OTHER INSURANCE AND DEPENDENT COVERAGE QUESTIONNAIRE

Please complete all sections that apply to you and return to your Human Resources Department

Complete all sections	Employer Information		Name of Your Employer		Group number as shown on your ID Card	
	Employee Information		Last Name First Name MI		Employee's Social Security Number	
			Home Address		Employee's Birth Date	
			City State Zip		Month Day YR	
				Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>		
Spouse Information		Last Name First Name MI		Spouse Birth Date		
		Is Spouse employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name of Employer:		Month Day YR		
				Is Spouse enrolled in an insurance plan through his/her employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Complete if Spouse has coverage under any other insurance plan	Spouse Insurance Information		Type of Plan	Coverage?	Approximate Effective Date	Name of Insurance Company
			Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Child(ren) Insurance Information		Type of Plan	Covered?	Approximate Effective Date	Name of Insurance Company
			Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Complete if you have children covered by your plan and responsibility for insurance coverage is outlined in a divorce decree	Child Full Name	Child Birthdate	Full Name of Parent Responsible for Coverage	Responsible Parents Birthdate	Copy of Divorce Decree Attached?	
		M D YR		M D YR	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		M D YR		M D YR	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		M D YR		M D YR	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		M D YR		M D YR	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Full-Time Student Information Attach proof of school registration	Child Full Name	Child Birthdate	Name of School	Full-Time Student?	Semester	
		M D YR		Yes <input type="checkbox"/> No <input type="checkbox"/>	Spring YR	
					Fall YR	
		M D YR		Yes <input type="checkbox"/> No <input type="checkbox"/>	Spring YR	
				Fall YR		
Employee Signature	Employee's Signature				Date	
					Month Day YR	



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