OTHER HEALTH INSURANCE (OHI) INFORMATION FORM
DEPENDENT CHILDREN

GROUP Name: _____ **Employee ID No.:** _____
GROUP Number: _____
EMPLOYEE Name: _____ **Employee Date of Birth:** _____

CHILD'S NAME:				Date of Birth:	
Relation to Employee:	__Natural Child, __Step-Child, __Adopted Child, __Foster Child, __Other (_____)				
If dependent child over 19, is he/she a full-time student?	___Yes ___ No	If yes, please provide a statement from the college or university stating full-time or part-time status for the Spring, Fall or both semesters. Failure to provide information could lead to a lapse in coverage.			
Address if different than Employee's:					
OHI: ___Yes ___ No	If yes, please provide the following information:	OHI Policy Holder Name:		Policy Holder's Date of Birth:	
OHI Policy Holder relation to Dependent: __Self, __ Parent, __Other (_____)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA		*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage:	___ Over 65 ___ Disabled ___ End Stage Renal Disease ___ Other _____				
OHI Policy Holder's Employer:		Group Number:		Policy ID Number:	
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					
Mother's Name, Address & Phone No.:					
Father's Name, Address & Phone No.:					
**Are the Child's Parents Separated or Divorced?	____ Yes ____ No	Who has physical custody?			

CHILD'S NAME:				Date of Birth:	
Relation to Employee:	__Natural Child, __Step-Child, __Adopted Child, __Foster Child, __Other (_____)				
If dependent child over 19, is he/she a full-time student?	___Yes ___ No	If yes, please provide a statement from the college or university stating full-time or part-time status for the Spring, Fall or both semesters. Failure to provide information could lead to a lapse in coverage.			
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OHI Carrier Name, Address & Phone Number:					
Mother's Name, Address & Phone No.:					
Father's Name, Address & Phone No.:					
**Are the Child's Parents Separated or Divorced?	____ Yes ____ No	Who has physical custody?			

If necessary, make copies and attach additional pages of this OHI Form for more dependent children.

* Creditable Coverage ***may*** be applicable under this plan. Please provide the Certificate of Creditable Coverage with this form, if possible. If received at a later time, provide a copy to your employer or Med-Pay as soon as received.

****** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

Please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

_____ _____
Employee Signature Date

Rev 11/2009