Coverage for Dependent Children Questionnaire Form

If you are a single, divorced, or separated parent of one or more dependent children, please complete this form.

The custodial parent of a dependent child assumes primary responsibility for providing the child's medical coverage, unless legally stated otherwise. By filling out this form, you'll help us to coordinate your child's health benefits and make sure you receive prompt, fair and accurate processing of your claims. It's also required by law that you disclose the information we've requested.

Please return this completed questionnaire form to the CIGNA HealthCare Claims Center listed on your CIGNA HealthCare ID card. If you have any questions or need assistance in completing this form, simply call the Claims Center and a representative will be happy to help you.

Please fill out form completely. **Please note: This form cannot be submitted online.** After filling in all of the fields, please print this form by clicking the button at the end of this form or by using your web browser's print function and mail it to the CIGNA HealthCare claims center listed on the back of your CIGNA HealthCare ID Card.

EMPLOYEE ENROLLED IN A CIGNA HEALTHCARE PLAN:

EMPLOYEE ADDRESS: *(Street)* *(Apt. #)* *(City)* *(State)* *(Zip Code)*

RELATIONSHIP: ☐ Self ☐ Spouse	CIGNA HEALTHCARE GROUP NUMBER:	CIGNA HEALTHCARE MEMBER ID NUMBER:

PLEASE PROVIDE THE FIRST AND LAST NAMES OF ALL DEPENDENT CHILDREN:

1. 4.
2. 5.
3. 6.

WHO HAS LEGAL CUSTODY OF THE ABOVE NAMED DEPENDENT(S)?	DO ANY DEPENDENT CHILDREN LIVE WITH YOU? ☐ Yes ☐ No

IF NO, PLEASE PROVIDE THE NAME, DATE OF BIRTH AND ADDRESS OF THE PARENT/GUARDIAN WITH WHOM THE DEPENDENT(S) LIVE(S):

Parent/Guardian Name: *Date of Birth:*

Address:

IS THE PARENT WHO DOES **NOT** HAVE LEGAL CUSTODY REQUIRED BY COURT DECREE TO BE FINANCIALLY RESPONSIBLE FOR THE CHILD(REN)'S HEALTH CARE EXPENSES? ☐ Yes ☐ No

IF A COURT ORDER ASSIGNS FINANCIAL RESPONSIBILITY TO ONE PARENT FOR MEDICAL/DENTAL CARE, PLEASE ATTACH A COPY OF THE ORDER.

PLEASE PROVIDE THE NAME AND SOCIAL SECURITY NUMBER OF THE PARENT REQUIRED TO PROVIDE HEALTH CARE COVERAGE:

Name: *Social Security Number:*

IS THE HEALTH CARE COVERAGE THROUGH AN EMPLOYER? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE THE EMPLOYER'S NAME AND ADDRESS:

Employer Name:

Address:

PLEASE PROVIDE THE NAME, POLICY NUMBER AND ADDRESS OF THE OTHER HEALTH CARE CARRIER:

Carrier: *Policy #:*

Address:

SIGNATURE:	DATE SIGNED:

Thank you for your cooperation in providing this information

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Clear Fields Print Form