



Request for Coverage of Foster Dependent

Subscriber Information		
Name (Last, First, MI)	Check if name change <input type="checkbox"/>	Health Plan ID#
Employer		
Dependent Information		
Name (Last, First, MI)		Social Security Number
Relationship	Date of Birth DDMMYY	Primary Care Physician
Support Information		
What percent of Dependent's support do you provide?	Date support began	
How long will this support continue?	Does the Dependent reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Give reasons why this Dependent lives with you and is dependent on you for support		

Legal documentation is REQUIRED for inclusion of a foster dependent on your contract (court order, county Social Services documentation, etc.) <i>Attach a copy of the document to this form</i>		
<small>I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERTO, COMMITS A FRADULENT INSURANCE ACT. THIS IS A CRIME AND THE PERSON SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.</small>		
Subscriber Signature	Date	
This section for Preferred Care Use Only		
<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Contract change needed? <input type="checkbox"/> Yes <input type="checkbox"/> No