



**DEPENDENT QUESTIONNAIRE**

Control Number or Tracking Number	
Employee Name	
Employee Social Security Number	
Child's Name	

Dear Employee:

Thank you for your request for coverage. Additional information is needed on the dependent child named above. Please answer the questions below, and fax or mail back to us at the address shown above.

1.	Provide the full name, date of birth and relationship of the dependent child to you?		
	Name		
	Date of Birth (Month, Day and Year)		
	Relationship		
2.	What is the relationship of this child? Check one:		
	<input type="checkbox"/> Step child	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece or Nephew
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Sister or brother	<input type="checkbox"/> Other
	When did he/she become a dependent under your care?		
	Month	Day	Year
3.	Is the child married?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Is this child financially dependent upon you for support? That is, do you claim this child as a dependent for federal income tax?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Does the child reside in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not, provide the address.		
	Street	City	State Zip
6.	If the child is 19 or over, is the child attending school on a regular basis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please provide a copy of the child's student status by submitting a copy of the Course Schedule or letter from the school confirming student status and credit hours.		

*This is to certify that the above is accurate. I understand that misstatement or misrepresentation may result in insurance coverage being void as of the effective date with no benefits payable. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Employee Signature		Date	
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