RETURN TO:
NAA – Eligibility Dept.
P O Box 1984
Nashville, TN 37202
Phone: 615-256-3561
Toll Free: 800-411-3650
Fax: 615-255-6654

naa | North America Administrators

DEPENDENT INFORMATION & INSURANCE VERIFICATION FORM

This form is to be completed by the Employee. Please complete a separate form for each Dependent.

EMPLOYER: ____

Employee: ____________________________________ SSN:____________________________

Dependent: ____ Dependent Date of Birth: __________________

Dependent SSN: ______________________________ Dependent Gender: ________

Relationship to Employee (CHECK ONE):

[ ] Natural Child [ ] Adopted Child [ ] Step-Child [ ] Other______________________________

1. Does the dependent have any other medical coverage currently in force? [ ] YES [ ] NO

   If NO, please sign and date below and fax or mail this completed form to NAA.

2. If YES, is there a Court Order that requires you or any other person to maintain health coverage for this dependent? [ ] YES [ ] NO

   If YES, please return a copy of the Divorce Decree or Court Order with this form.

3. Does the responsible party have Group-Sponsored Health Coverage? [ ] YES [ ] NO

If YES, provide the following information for the other insurance carrier or plan and **return a copy of that insurance card with the form**:

Company Name/Address____

Policy/Group No.____________________ Telephone No. _______________________________________

Name of Insured: _____________________________________ Insured's Date of Birth: ______________

Relationship to Dependent: ____

I hereby certify that the above statements are true and complete to the best of my knowledge and I realize that failure to provide accurate information may cause a loss of benefits.

____ ______________________

Employee Signature **Date**