## **HEALTH INSURANCE INFORMATION** DCSS 0054 (04/27/2005)

County:	ty: Phone: 866-901-3212					LCSA Case Number:					
Noncustodial Parent:											
Full Name (First, Middle, Last, Suffix)				I am the ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer							
Address (Street)		Light Employer City, State, Zip Code									
Phone			Soci	Social Security Number							
Employer (Name, street, ci	ty, state, zip code, pho	ne)									
date the	ON II is about the other completed form.	er parent's insu									
SECTION I: YOUR F	IEAL I II INSUKAI	NCE									
HEALTH INSURANCE: <u>Do you currently have Hea</u> Health Insurance Company	th Insurance coverage		No r)	Provid C	f Yes, please co ded by: ustodial Party mployer	mplete the following  Noncusto Other: Relations	dial Parent				
Insurance Company's Addi (Address where claims are		Number or Unit	Number			Telephone Numb	er				
City State Zip Code					Policy Number	1					
Premium Amount \$ Check On		Check One:	Weekly		Bi-Weekly	Semi-Mont	hly				
Amount You Pay \$		Check One:	Weekly		Bi-Weekly	Semi-Monthly					
Amount Employer Pays \$		Check One:	Weekly		Semi-Monthly						
Amount of deduction applied to employee's portion of Health Insurance \$		Amount of deduction applied to dependent's portion of Health Insurance \$									
Dependent(s) Currentl	y Covered By Heal	th Insurance									
Name (First, Middle, Last)	Social Security Number	Sex Date	e of Birth	Policy Number(s) Start Date		Start Date	End Date				
1.											
2.											
3.											
4.											
5.											
6.											
Please check this box if separate sheet. Please Not available to depend	attach the sheet.	I I nbers of addition	al dependent	s covere	ed by your Healt	I h Insurance are liste	d on a				

The Policy covers the followi	ng: (Check all that a	pply)								
Doctor Visits	Medicare Supplem	ental	☐ Specifi	c IIIr	ness			Preso	ription Dru	gs
☐ Long Term Care ☐	Hospital Stays		☐ Hospita (i.e., la	al O b w	utpatient ork, physica	al ther	гару)	Other	(Specify):	
DENTAL INSURANCE:			🗆							
Do you currently have Denta Dental Insurance Company	I Insurance coverag	e? ∟	Yes ☐ No	)	If	Yes,	please com	plete th	ne following	J.
Demai insurance company										
Dental Insurance Company's	s Address: Street, Ap	oartme	nt Number or U	nit N	Number (ad	ddress	where clair	ms are	mailed)	
City	State		Zip Code					Poli	cy Number	
Premium Amount \$			Check One:		Weekly		Bi-Week	kly	Ser	ni-Monthly
Amount You Pay \$			Check One:		Weekly		Bi-Week	кly	Ser	ni-Monthly
Amount Employer Pays \$			Check One: Weekly			Bi-Weekly Semi-Monthly				
Amount of deduction applied			Amount of deduction applied to dependent				ependent's			
portion of Health Insurance §  Dependent(s) Covered by		200	portion of he	alth	insurance	\$			\$	
Name (First, Middle, Last)	Social Security	Sex	Date of Birth		Policy N	lumbo	r(c)	Stort	Date	End Date
TVairie (First, Midule, Last)	Number	Sex	Date of Billi	<u> </u>	Policy IV	iumbe	1(5)	Start	Dale	Life Date
1.										
2.										
3.										
4.										
5.										
6										
6.										
Please check this box if n separate sheet of paper.  Not available to depende	Please attach the sh	mbers neet.	of additional de	pen	idents cove	ered by	your Denta	al Insui	rance are li	sted on a
VISION INSURANCE:										
Do you currently have Vision	Insurance coverage	e? 🗌	Yes	lo	If Yes	s, plea	se complete	e the fo	llowing.	
Vision Insurance Company										
Vision Insurance Company's	Address: Street, Ap	artmer	nt Number or U	nit N	Number (Ad	dress	where clair	ns are	mailed)	
City	State		Zip Code				Policy I	Numbe	r	
Premium Amount \$			Check One:	П	Weekly		Bi-Weekly	/	Semi	-Monthly
Amount You Pay \$			Check One:		Weekly		Bi-Weekly	/		-Monthly
Amount Employer Pays \$			Check One:	=	Weekly	一百	Bi-Weekly			-Monthly
Amount of deduction applied portion of Health Insurance \$			ount of deducti	on a	applied to d	lepend				additional child
Dependent(s) Covered b					ασσ φ			Ι Ψ		
Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	า	Policy	y Num	ber(s)	St	art Date	End Date
1.	Number									
2.										
3.										
4.										
5.										
6.										
Please check this box if n separate sheet. Please a Not available to depende	ttach the sheet.	mbers	of additional de	pen	dents cove	ered by	your Visio	n Insur	ance are lis	sted on a

SECTION II: OTHER PARENT'S INSURANCE
HEALTH INSURANCE:  Does the other parent currently provide Health Insurance coverage for the child(ren) or you?   Yes   No If Yes, please complete the following information.
Health Insurance Company
Health insurance Company's Address: Street, Apartment Number or Unit Number (Address where claims are mailed)
City State Zip Code
DENTAL INSURANCE:  Does the other parent currently provide Dental Insurance coverage for the child(ren) or you?   Yes   No  If Yes, please complete the following information.
Dental Insurance Company
Dental Insurance Company's Address: Street, Apartment Number or Unit Number (Address where claims are mailed)
City State Zip Code
VISION INSURANCE:  Does the other parent currently provide Vision Insurance coverage for the child(ren) or you?   Yes   No  If Yes, please complete the following information.
Vision Insurance Company
Vision Insurance Company's Address: Street, Apartment Number or Unit Number (Address where claims are mailed)
City State Zip Code
SECTION III: (MUST BE COMPLETED)
☐ I have enclosed the insurance card(s)/information about the coverage for the child(ren).
At this time I do not have the insurance cards/information about the coverage for the child(ren). I will send the information to you when
get it from the insurance company.
At this time there is no health insurance coverage available. I understand that if it becomes available, I will have to add my child(ren) onto the plan and then notify the local child support agency of the coverage. Coverage is unavailable because:
☐ Not offered ☐ Seasonal ☐ Part-Time ☐ Refused enrollment ☐ Unreasonable in cost ☐ Probationary period/date eligit
PRIVACY STATEMENT
The information Practices Act of 1997 (Civil Code Section 1798.17) and the Federal Privacy Act of 1974 (Public Law 93-579) require this notice be provided when collecting personal information from individuals. Information requested on this form, including Social Security Number, is used by the Department of Child Support Services (DCSS) for purposes of identification and communication with you. The DCSS is required, under Section 466 (a)(13) of the Social Security Act, to collect the Social Security Number of any individual who is subject to a divorce decree, support order, or paternit determination or acknowledgement.
Social Security Number information is mandatory and will be kept on file at the local child support agency to locate and identify individuals and as for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the oparent.
The information in your case may be discussed with or given to the State, other agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law.
SIGNATURE DATE
PRINTED NAME TELEPHONE (include Area Code)
TITLE