univera HEALTHCARE

P.O. Box 211256, Eagan, MN 55121

DEPENDENT/ ADOPTED CHILD FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#_____

EC_____

✓CHECK DESIRED ACTION

☐ (FD) Add Dependent
Desired Eff Date_____

☐ (AP) Add Adopted Dependent
Desired Eff Date_____

Please complete this application for Dependent /Adopted child membership
Mail form to: Univera Healthcare P.O. Box 211256, Eagan, MN 55121

SUBSCRIBER INFORMATION – MUST BE COMPLETED Married: ☐ Yes ☐ No Date of marriage ☐☐☐☐☐☐

Social Security # ☐☐☐-☐☐-☐☐☐☐ Sex ☐ M ☐ F Birthdate: ☐☐☐☐☐☐

Last Name First Name

Street

City State ☐☐ Zip ☐☐☐☐☐

Work Phone Number Home Phone Number Cell Phone Number

☐☐☐-☐☐☐-☐☐☐☐/☐☐☐-☐☐☐-☐☐☐☐/☐☐☐-☐☐☐-☐☐☐☐

DEPENDENT INFORMATION – MUST BE COMPLETED

Last Name First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Current Patient of PCP? ☐ Yes ☐ No

Are you a Current Patient of Ob/Gyn? ☐ Yes ☐ No

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Is your over-age dependent handicapped or disabled? ☐ Yes (See last page for additional information) ☐ No

Is child a Foreign Exchange Student? ☐ Yes ☐ No, If yes, request coverage from ☐☐☐☐☐☐ to ☐☐☐☐☐☐

Is Dependent a full time student? ☐ No ☐ Yes

If yes, please indicate: Name of School:

OTHER COVERAGE INFORMATION- MUST BE COMPLETED

You may be contacted for additional information. In addition, please provide a copy of your "Certificate of Coverage" from your former dental insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? ☐ Yes ☐ No /Dental? ☐ Yes ☐ No

If answering "Yes", are you keeping the additional health or dental coverage? Health? ☐ Yes ☐ No /Dental? ☐ Yes ☐ No

If No, indicate cancel date- Health ☐☐☐☐☐☐ Dental ☐☐☐☐☐☐

Policyholder's **Last** Name First Name M.I.

Effective Date: ☐☐☐☐☐☐ Did this insurance cover ☐ Insured ☐ Insured and Family

✓ Check previous insurance company from list below and indicate ID #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ (B) UniveraHealthcare

☐ (O) Other - Blue Cross Blue Shield Plan. Indicate Plan Name:

☐ (C) Other Carrier - Indicate Plan Name:

DEPENDENT CHILD - Please complete this section if you are applying for coverage for a child for whom you are the legal guardian or for an adopted child, or a child that has been placed with you for adoption.
Acceptable legal documentation includes:

- For legal guardianship
  A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship
- For an adopted child
  A copy of court documents signed by a judge showing that the subscriber has adopted the child; or international papers from the country of adoption; or papers from adoption agency showing intent to adopt.

1. Relationship to Subscriber

2. Mother's Last Name First Name

Mailing Address

City State Zip

Date of Birth

3. Father's Last Name First Name

Mailing Address

City State Zip

Date of Birth

Adoption – Inasmuch as I am legally obligated to support this child during the period prior to completion of the adoption proceedings, I hereby apply for the inclusion of this child as a family member under my health plan.
Legal Guardianship- A child for whom the subscriber is the legal guardian is eligible. Please note custody alone is not sufficient. A court must specifically confer legal guardianship. The child is eligible for coverage the date of the court order.
Please submit your acceptable legal documentation along with this form (placement agency papers, letter from law firm/attorney on law firm/attorney letterhead, papers from country of birth)**.**

I hereby certify that on the date (mm/dd/yy) of ☐☐☐☐☐☐ I began legal proceedings for the adoption of the child noted above.

DEPENDENT – I hereby apply for inclusion of this child as a family member under my health plan. I agree to notify Univera Healthcare when a change in status occurs.
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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

Subscriber Signature_____Date _____

If you have any questions, please contact your Group Representative/Administrator.
Or, visit us at: www.univerahealthcare.com