How to fill out

HEALTH INSURANCE INFORMATION

DIRECTIONS:

- The Health Insurance Information form has been sectioned off for instructional purposes to assist you in filling each section within the form, there is a total of 3 pages to be filled out and completed.
- Find the number or a letter on the sample form. Example 1 OR **a.**
- Go to the same number below or next to the sample form to find out how to fill out the form.
- Type or print in black ink.

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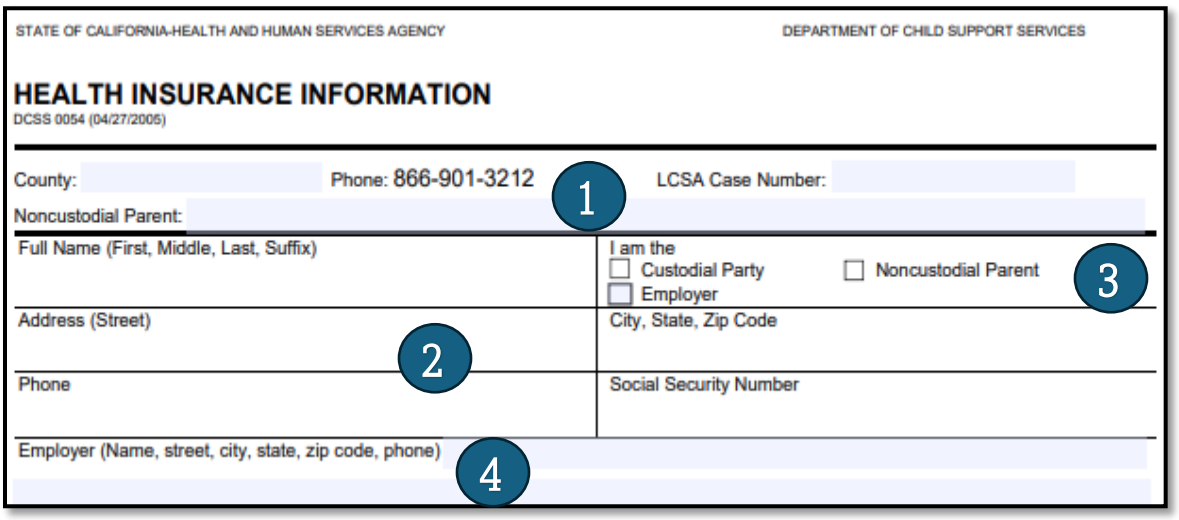


STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY — DEPARTMENT OF CHILD SUPPORT SERVICES

HEALTH INSURANCE INFORMATION

DCSS 0054 (04/27/2005)

County: | 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) | City, State, Zip Code

Phone | Social Security Number

Employer (Name, street, city, state, zip code, phone)

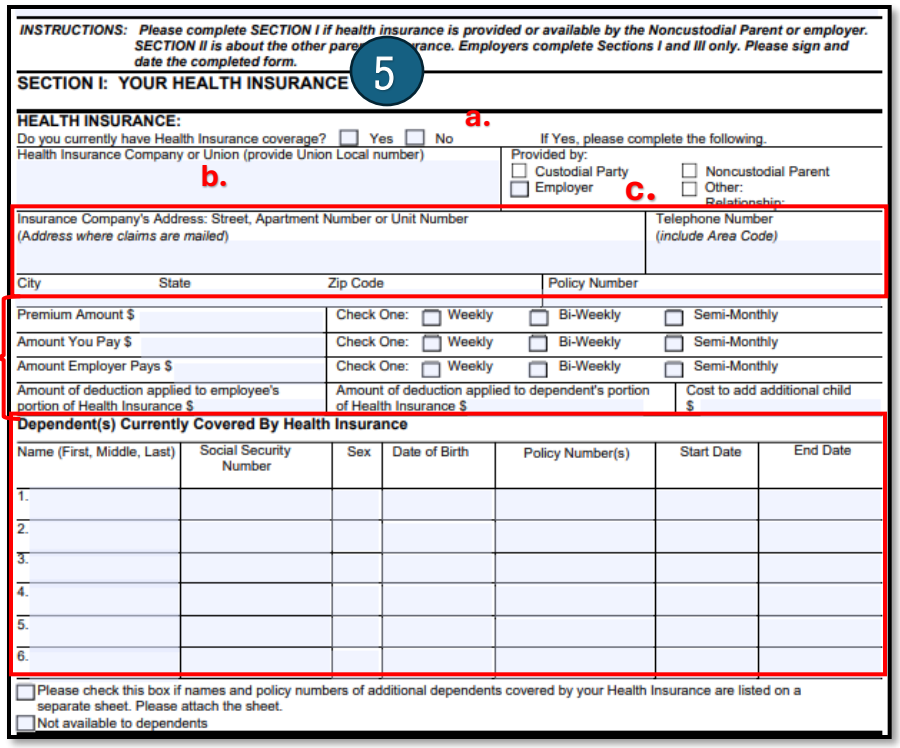
1 **County**: Kern County. **LCSA Case Number**: Provide your case number if known, otherwise leave it blank. **Noncustodial Parent:** Print the full of the parent who is paying support.

2 Print your **Full Name** (First, Middle, Last, Suffix), current **Address**, current **Phone** number & your **Social Security Number**.

3 Check the appropriate box. **Custodial** Party is the party who is **RECEIVING** support and **Noncustodial** Parent is the parent **PAYING** support.

4 Print your **Employers** information, if you are employed. Provide Name, Address and Phone number of your employer.

5 **Section I**: Provide your Health Insurance information. You can find this information on your paycheck stub and insurance card.



INSTRUCTIONS: Please complete SECTION I if health insurance is provided or available by the Noncustodial Parent or employer. SECTION II is about the other pare…rance. Employers complete Sections I and III only. Please sign and date the completed form.

5

SECTION I: YOUR HEALTH INSURANCE

HEALTH INSURANCE:

Do you currently have Health Insurance coverage? ☐ Yes ☐ No — If Yes, please complete the following.

a.

Health Insurance Company or Union (provide Union Local number)

b.

Provided by: ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer c. ☐ Other: Relationship:

d.

Insurance Company's Address: Street, Apartment Number or Unit Number (Address where claims are mailed)

Telephone Number (include Area Code)

City | State | Zip Code | Policy Number

e.

Premium Amount $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	
Amount You Pay $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	
Amount Employer Pays $	Check One: ☐ Weekly ☐ Bi-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 $	Cost to add additional child $

Dependent(s) Currently Covered By Health Insurance

f.

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Health Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

a. Indicate if you have or do not have health insurance by marking the correct box under. If you marked Yes, you will need to complete SECTION I.

b. If you currently have Medi-Cal indicate in the Health Insurance Company section.

c. Mark the appropriate box to indicate who is providing medical insurance listed or the policy holder.

d. Print the Insurance company's address & telephone number and Policy Number.

e. You will find this information on your paycheck stub & insurance card.

f. Include all dependents listed or included in your Health Insurance policy.

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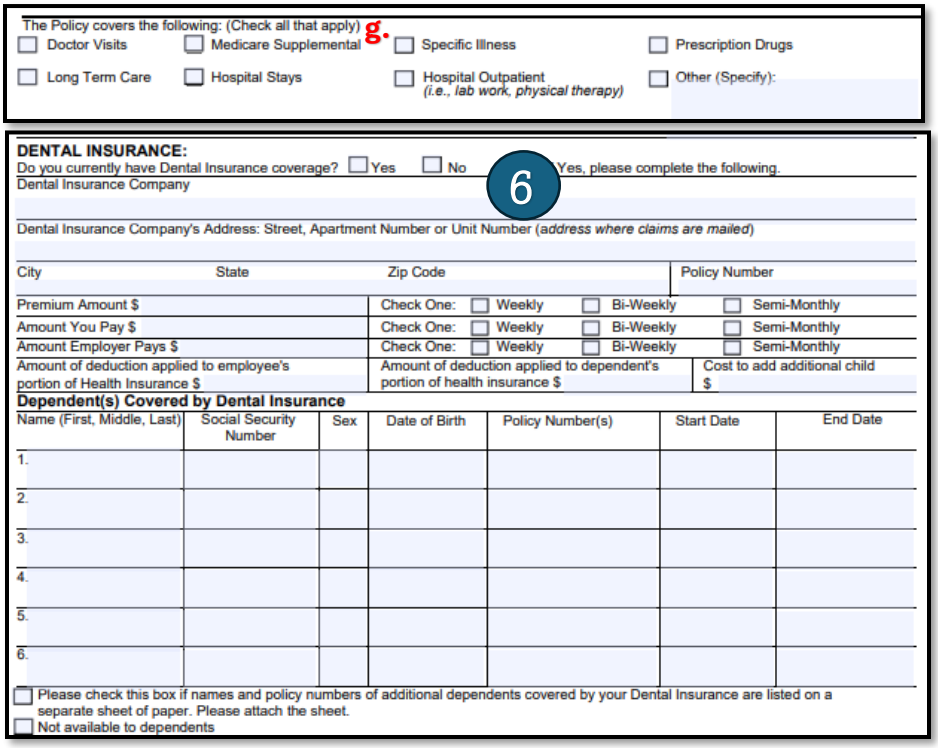


The Policy covers the following: (Check all that apply)

g.

☐ Doctor Visits ☐ Medicare Supplemental ☐ Specific Illness ☐ Prescription Drugs

☐ Long Term Care ☐ Hospital Stays ☐ Hospital Outpatient (i.e., lab work, physical therapy) ☐ Other (Specify):

DENTAL INSURANCE:

Do you currently have Dental Insurance coverage? ☐ Yes ☐ No — Yes, please complete the following.

6

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (address where claims are mailed)

City | State | Zip Code | Policy Number

Premium Amount $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	
Amount You Pay $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	
Amount Employer Pays $	Check One: ☐ Weekly ☐ Bi-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 $	Cost to add additional child $

Dependent(s) Covered by Dental Insurance

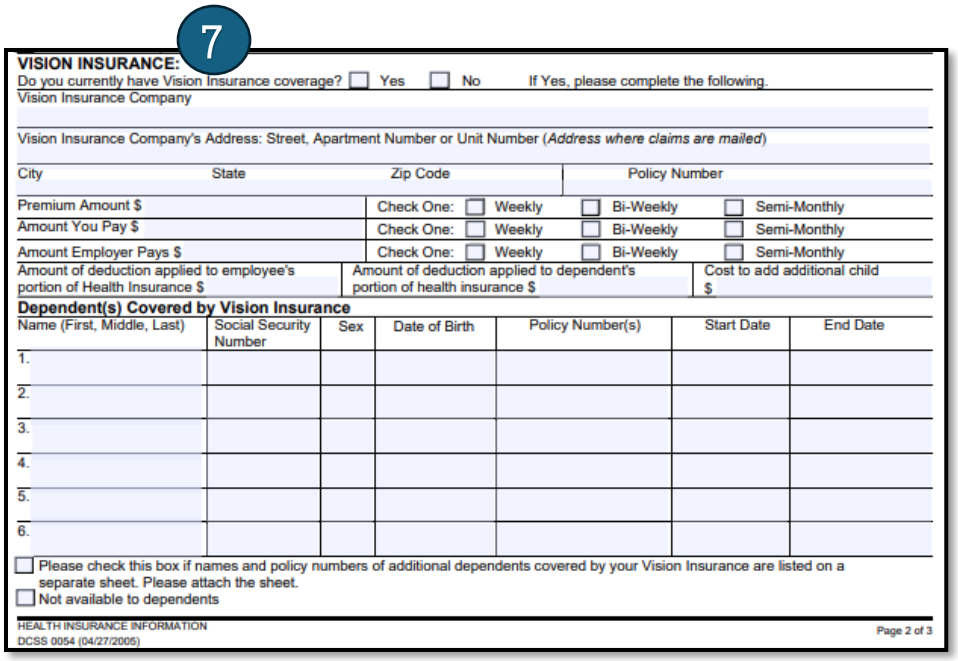
Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Dental Insurance are listed on a separate sheet of paper. Please attach the sheet.

☐ Not available to dependents

g. Check all that apply in regard to what your insurance policy covers.

6 **DENTAL INSURANCE:** Provide your Dental Insurance information and indicate whether you have coverage or not. If you have dental insurance, you will need to complete this section similar to the Health Insurance section above.



VISION INSURANCE:
Do you currently have Vision Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.
Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City | State | Zip Code | Policy Number

Premium Amount $ | Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount You Pay $ | Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount Employer Pays $ | Check One: ☐ Weekly ☐ Bi-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 $ | Cost to add additional child $

Dependent(s) Covered by Vision Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Vision Insurance are listed on a separate sheet. Please attach the sheet.
☐ Not available to dependents

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7 **VISION INSURANCE:** Provide your Vision Insurance information and indicate whether you have coverage or not. If you have vision insurance, you will need to complete this section similar to the Health Insurance & Dental sections above.

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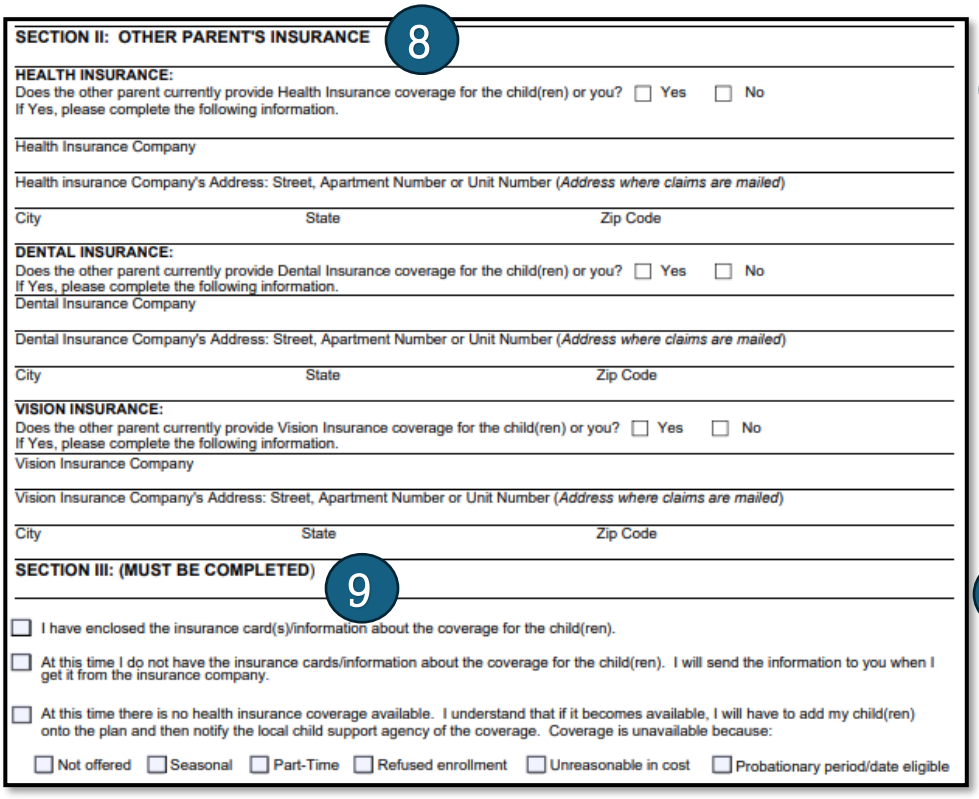


SECTION II: OTHER PARENT'S INSURANCE

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).

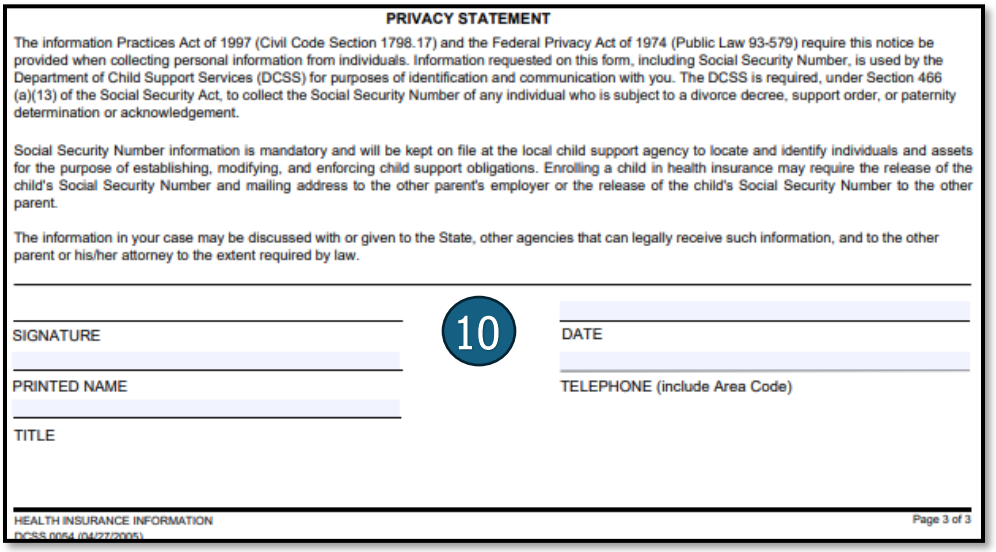
☐ At this time I do not have the insurance cards/information about the coverage for the child(ren). I will send the information to you when I get it from the insurance company.

☐ 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 eligible

8 **SECTION II: OTHER PARENT'S INSURANCE:** You will provide HEALTH INSURANCE, DENTAL INSURANCE and VISION INSURANCE information if the other parent provides insurance coverage for the children.

9 **SECTION III:** You must select the most appropriate box.



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 paternity 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 assets for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of the 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 other parent.

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

10

DATE

PRINTED NAME

TELEPHONE (include Area Code)

TITLE

HEALTH INSURANCE INFORMATION

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10 Read the **PRIVACY STATEMENT**. Then Sign your name, Print your name, Date and provide your telephone number.