Dependent Data Collection Form for Health Benefit Enrollment

Please note that ***this is not an enrollment form***. You must complete the enrollment process by meeting with a benefits counselor.

Employee Name (Last, First, Middle):	Phone No.:

Coordination of Benefits: Do you or any of your dependents have any other health plan or health insurance (including Medicare) in addition to the Prime Medical EPO Coverage? ☐ Yes ☐ No

If yes, will this coverage remain in effect after the Prime Medical EPO coverage begins? ☐ Yes ☐ No
Name and Group number of other Coverage ______________________________

COVERED INDIVIDUALS (Please print Names, Birthdates and Social Security Numbers)

Spouse Name (Last, First, Middle Initial)	Gender	Relationship	Birth Date	SS# **(Required)**
	☐ M ☐ F	SPOUSE ☐ RDP ☐ Disabled?		

Please choose a statement that applies to your spouse:
☐ Named spouse or domestic partner is not employed or is self-employed and does not have access to an employer sponsored medical plan.
☐ Named spouse or domestic partner is actively employed by your facility.
☐ Named spouse or domestic partner is employed and his/her employer offers medical coverage or a contribution toward purchasing medical coverage.
☐ Named spouse or domestic partner is employed but his/her employer does not offer medical coverage or a contribution toward purchasing medical coverage.

Child Dependent Name (Last, First, Middle Initial)	Gender	Relationship	Birth Date	SS# **(Required)**
	☐ M ☐ F	CHILD ☐ Disabled?		
	☐ M ☐ F	CHILD ☐ Disabled?		
	☐ M ☐ F	CHILD ☐ Disabled?		
	☐ M ☐ F	CHILD ☐ Disabled?		
	☐ M ☐ F	CHILD ☐ Disabled?		

I attest by signing below that I have reviewed the information provided on this form and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements. I also certify that the information I provided on this form and at all times during coverage about my family status and my dependents' eligibility for benefits under the benefit plan is accurate. I understand that coverage may be rescinded in the event of fraud or a material misrepresentation, and such rescission is effective on the date of such fraud or misrepresentation.

Fraud Warning: I further understand that any person who knowingly, and with intent to defraud any insurance company, or other person, files an application for insurance or a statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature >	Signature of witness (only required if employee signature is "X")	Date	**HR Use Only** Entered: