HEALTH INSURANCE INFORMATION

Page 1 of 2		WIA I IOI							
FULL NAME (First, Middle, Last,	Suffix)								CUSTODIAL PARTY
-									NONCUSTODIAL PARENT
SECTION I: YOUR INSURA Complete this section if yo	ur insurance is	provided or av	ailable	e through y	our e	employer or a p	orivat	e policy ma	intained by you and not
the other parent. Section	II is about the in	nsurance provi	ded by	y the other	pare	nt.			
HEALTH INSURANCE	neurance coverag	e? YES		NO If YES		nniete the fellew		farmatian	
Do you currently have Health I HEALTH INSURANCE COMPANY	risurance coverag	er TES		NO ITTE	s, con	nplete the follow	ing in	rormation.	
INSURANCE COMPANY'S ADDRES	CC: Street Ant or I	hit No. (Address	uhoro o	laima ara maila	۷۱				
INSURANCE COMPANY S ADDRES	ss. street, Apt. or o	riit No. (Address v	vnere c	iaims are maned	1)				
City, State, Zip Code							POLIC	CY NO.	
PREMIUM DEDUCTION AMOUNT	<u> </u>								AMOUNT PAID BY EMPLOYER
	CHECK ONE:	W⊞KLY		BI-WŒKLY		SEMI-MONTHLY		MONTHLY	7
AMOUNT PAID BY YOU	CHECK ONE:	WEEKLY		BI-WEEKLY		SEMI-MONTHLY		MONTHLY	
NAME(S) OF DEPENDE	I NTS CURRENTLY		EALTH			<u> </u>			S POLICY NO.
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
Check here if names &	policy numbers o	of additional depe	endent	s covered by	Healt	th Insurance are	list ed	on a separat	e sheet attached.
DENTAL INSURANCE Do you currently have Dental I	nsurance coverag	e? YES		NO If YES	S con	nplete the follow	ina in	formation	
DENTAL INSURANCE COMPANY	modi diloo oo voldg	<u> </u>		I I I I I I I I I I I I I I I I I I I	3 , con	inplete the follow	ilig ili	TOTTIALIOTI.	
INSURANCE COMPANY'S ADDRES	SS: Street Ant or L	Init No (Address v	vhere c	laims are maile	7)				
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City, State, Zip Code							POLIC	CY NO.	
PREMIUM DEDUCTION AMOUNT				1		<u> </u> 1			AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE:	WEKLY		BI-WŒKLY		SEMI-MONTHLY		MONTHLY	
AMOGNITALD DI 100	CHECK ONE	WEEKLY		BI-WEEKLY		SEMI-MONTHLY		MONTHLY	
NAME(S) OF DEPENDE	NTS CURRENTLY	COVERED BY D	ENTAL	. INSURANCE				EPENDENT'	S POLICY NO.
1.									
2.									
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Check here if names 8	nolicy numbers o	of additional dans	an dan t	e covered by	Dent	al Ingurance are	liet od	on a cenarat	e sheet attached

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Page 2 of 2 **VISION INSURANCE** YES NO If YES, complete the following information. Do you currently have Vision Insurance coverage? VISION INSURANCE COMPANY INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed) City, State, Zip Code POLICY NO. PREMIUM DEDUCTION AMOUNT AMOUNT PAID BY EMPLOYER BI-WŒKLY MONTHLY CHECK ONE: WEEKLY SEMI-MONTHLY AMOUNT PAID BY YOU BI-WEEKLY SEMI-MONTHLY CHECK ONE: WEEKLY MONTHLY NAME(S) OF DEPENDENTS CURRENTLY COVERED BY VISION INSURANCE DEPENDENT'S POLICY NO. 1. 2. 3. 4. 5. 6. 7.

SECTION II: OTHER PARENT'S INSURANCE

		_				
Does the other parent currently provide Health Insurance coverage for the children or you?	YES		NO	If YES,	complete the f	ollowing

		information.
HEALTH INSURANCE COMPANY		
INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)		
City, State, Zip Code		

Check here if names & policy numbers of additional dependents covered by Vision Insurance are listed on a separate sheet attached.

DENTAL INSURANCE

HEALTH INSURANCE

8.

Does the other parent currently provide Dental Insurance coverage for the children or you? YES NO If YES, complete the following information.

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code

VISION INSURANCE

Does the other parent currently provide Vision Insurance coverage for the children or you?

YES		NO	If YES, co
			informatio

If **YES**, complete the following information.

VISION INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code