OTHER INSURANCE AND DEPENDENT COVERAGE QUESTIONNAIRE

Please complete all sections that apply to you and return to TRISTAR Benefit Administrators

Complete all sections

Employer Information

Name of Your Employer	Group number as shown on your ID Card	Today's Date Month Day YR

Employee Information

Last Name First Name MI	Employee's Social Security Number
Home Address	Employee's Birth Date Month Day YR
City State Zip	Marital Status: Single ☐ Married ☐ Divorced ☐

Spouse Information

Last Name First Name MI	Spouse Birth Date Month Day YR
Is Spouse employed? Yes ☐ No ☐ If Yes, Name of Spouse's Employer:	Is Spouse enrolled in an insurance plan through his/her employer? Yes ☐ No ☐

Please answer the questions at the right to let us know if your spouse and/or dependents are covered under *any other insurance plan - NOT including this TBA Plan.*

Spouse Insurance Information

Other Insurance Coverage?	Type of Plan	Approximate Effective Date	Name of Insurance Company
Yes ☐ No ☐	Medical ☐		
Yes ☐ No ☐	Dental ☐		
Yes ☐ No ☐	Vision ☐		

Child(ren) Insurance Information

Other Insurance Coverage?	Type of Plan	Approximate Effective Date	Name of Insurance Company
Yes ☐ No ☐	Medical ☐		
Yes ☐ No ☐	Dental ☐		
Yes ☐ No ☐	Vision ☐		

Other Insurance in Divorced Parent or Qualified Medical Support Order Situations (Please attach copy)

Child Full Name	Child Birthdate	Full Name of Parent Responsible for Coverage	Responsible Parents Birthdate	Copy of Divorce Decree Attached?
	M D YR		M D YR	Yes ☐ No ☐
	M D YR		M D YR	Yes ☐ No ☐
	M D YR		M D YR	Yes ☐ No ☐
	M D YR		M D YR	Yes ☐ No ☐

<u>Post High School</u> Full-Time Student Information

Please attach proof of school registration

Child Full Name	Child Birthdate	Name of School	Full-Time Student?	Semester
	M D YR		Yes ☐ No ☐	Spring ☐ Year _____ Fall ☐ Year _____
	M D YR		Yes ☐ No ☐	Spring ☐ Year _____ Fall ☐ Year _____

Employee Signature

Employee's Signature	**<u>Today's Date</u>** Month Day YR

TRISTAR Benefit Administrators
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