Dependent Addition Form

Fill out completely by typing or printing in ink

This form must be completed and returned within the next 30 days.

Name of Member:_____

Member's Subscriber/ Member ID Number: _____

Home Address:_____

Number and Street City State Zip

In addition to the following information, you must submit all the necessary documents to provide proof of eligibility; this includes, Certificate of Creditable Coverage, Marriage Certificate, Birth Certificate(s), Divorce Decree or other legal documents clarifying legal custody, financial responsibility and health insurance liability.

DEPENDENT('S) FULL LEGAL NAME	**SEX M/F**	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER** (Required for all enrolled)	***RELATIONSHIP***

If additional space is needed, please attach separate sheet

If any of the above listed dependents do not reside with you, provide their address:

_____

_____

Effective Date of Change:_____

Qualifying Event (Reason):_____

(Requests must be made within 30 days of a Qualifying Event.)

I certify that the above information is true and correct

_____ _____

Signature of Member Date

NOTE: This information needs to be received in our office in a timely manner. We do not accept faxes. All parts of this form must be completed to assure validity and to update eligibility. Please send completed forms to Wisconsin Health Fund, 1314 N Stoughton Rd, Madison, WI 53714. If you have any questions regarding this form, call WHF Customer Service at 1-888-208-8808.

Complete, sign and date both sides of this form

(See Back)

COORDINATION OF BENEFITS

Wisconsin Health Fund maintains a "Coordination of Benefits" provision, which allows the Fund to verify other coverage which you or any of your covered dependents may currently have in force. This information is necessary to establish the order of payment when two or more Plans cover an individual.

Do you, your spouse, or any of your covered dependents have any other health, prescription, dental, or optical coverage provided through a current employer, former employer, stepparent, natural parent, retiree plan, or Medicare?

(Please check one) _____**YES** _____**NO**

If YES, please complete the information requested below. If NO, simply supply your 9 digit Member ID number and sign below.

Coverage, other than WHF, provided through (check all that apply):

___Current Employer ___Former Employer ___Stepparent ___Natural Parent

___Retiree Plan ___Medicare Part A, B, and/or D ___Medicare Supplement ___ Medicaid

Name & Address of Insurance Carrier:_____

_____Phone: (_____)_____

Name of Policyholder:_____

Policyholder's Social Security Number:_____Policyholder's Birthdate:_____

_____ _____ _____

Effective Date of Coverage Group Number Policy Number

Type of Coverage (check all that apply):

___Medical ___Prescription Drugs ___Dental ___Optical

___Family ___Single

Date of Termination (if applicable):_____

Name of all individuals covered under this policy:_____

_____

Provide copies of any health carrier identification cards, including Medicare.

I certify that the information given to the above questions is true and correct.

_____

Print Name

_____ _____

Signature of Member Subscriber/Member Number (see ID card)

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