

DEPENDENT VERIFICATION FORM

DATE _____

Dear Employee:

To provide or continue coverage of the dependent named below, please answer *all* of the questions below. Mail the completed form to:

**Administration Department
Medical Claims Management Corporation
PO Box 12995
Charlotte, NC 28220-2995**

Employee: _____

Employee Social Security Number: _____

Employer _____

Dependent _____

1. What is the relationship of this dependent to the employee? _____

Natural Mother's Name: _____

Relationship to Employee: _____

Natural Father's Name: _____

Relationship to Employee: _____

2. With whom does this dependent live? _____

3. Date acquired as Dependent? _____

4. If you are providing coverage for this dependent via legal custody, adoption, guardianship or adoption placement, **please attach a copy of the court order or adoption documents.**

5. If you are providing coverage for this dependent through a divorce or separation agreement, please attach a copy of the legal agreement (court order) to this form.

6. Is this dependent covered under another policy? _____

If so, Name of Policyholder _____

Carrier Name _____

Policy Number _____

Type of coverage (medical and/or dental) _____

Effective date of other coverage _____