

Dependency Questionnaire

Return this form to:
Benefit Consultants, Inc.
13515 Barrett Parkway Dr., Suite 265
Ballwin, MO 63021

Section I: Participant Information

Name:	Address:	PIN # or SS#:
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Section II: List below eligible dependents

Dependent Name	Date of Birth	Relationship *	Sex	Dependent SSN	Address (if different than employee's)
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		

*Must designate (A) spouse, (B) natural child, (C) stepchild, (D) foster child, or (E) adopted child.

Section III: Eligibility Certification

To qualify for coverage under this Plan, your children must meet all of the requirements of the Plan's definition of eligible dependents and must qualify as an eligible dependent for income tax purposes.

Do all of the children listed above qualify as eligible dependents for the purpose of Income Tax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all of the children dependent on you for support and maintenance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you claim all of the children as dependents for Income Tax Purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered **NO** to any of the questions above, please identify the child and provide further explanation of your negative response.

Section IV: Other Group Coverage Information

Please list the name, address and date of birth for each parent or stepparent:

Name: Address: Date of Birth:	Name: Address: Date of Birth:
Name: Address: Date of Birth:	Name: Address: Date of Birth:

Are any of the children listed above covered under any other group insurance plan such as through your spouse's employment or, in the case of a divorce situation, through the stepparent's employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please provide the name of the person(s) and the employer(s) providing other health coverage and the name(s), addresses(s) and policy number(s) of all other health coverage.

If there is a court order assigning responsibility for health coverage to a specific individual or parent, please include a copy of that order with your response to this questionnaire. An example of such an order is a Qualified Medical Child Support Order (QMCSO) or that part of a divorce decree which addresses those responsible for providing health coverage for this child(ren).

I certify that the above information is true and complete and that if any changes occur, I will promptly notify Benefit Consultants, Inc.

Participant's Signature	Date
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