



OBLIGOR INSURANCE QUESTIONNAIRE

Date: _____
 Case Number: _____
 Worker ID: _____
 Worker: _____
 Child Support Recovery Unit

Payee Name: _____
 Child(ren): _____

Dear Parent:

The Child Support Recovery Unit (CSRU) is responsible for gathering health care coverage information for the child(ren) listed above. Please provide us with information on the health benefit plan that you provide for your child(ren). **Complete this form and return it to CSRU within 10 days.**

Health Care Coverage Questions
Do you have a health benefit plan for the child(ren) listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is there a health benefit plan available for the child(ren) through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer name:
Employer Address:
Location of work site:

If you currently have a health benefit plan for your child(ren), also complete the following pages and return this entire form to CSRU using the address listed above.



Health Benefit Plan Information

Name of person providing the health benefit plan:

Dependent Name(s):

Major Medical

Policy Number:

Effective Date:

Insurance Company Name:

Claims Address/Phone Number:

What is the monthly cost of a family plan?

What is the monthly cost of a single plan?

Prescription Drugs

Policy Number:

Effective Date:

Insurance Company Name:

Claims Address/Phone Number:

What is the monthly cost of a family plan?

What is the monthly cost of a single plan?

Vision

Policy Number:

Effective Date:

Insurance Company Name:

Claims Address/Phone Number:

What is the monthly cost of a family plan?

What is the monthly cost of a family plan?



Dental	
Policy Number:	Effective Date:
Insurance Company Name:	
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	
Other	
What is the type of plan?	
Policy Number:	Effective Date:
Insurance Company Name:	
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

If your health benefit plan is not provided through your employer, what is the name of the group or source providing the coverage?

NOTE: If your health care coverage should lapse or change for the child(ren), you must inform CSRU. Any contact CSRU makes with your current or future employers may include requests for health care coverage information.

Signature	Date
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Case Number: _____
 Worker ID: _____

