Department of HUMAN SERVICES

Insurance Questionnaire

County No. _____
Worker No. _____

To ensure that your claims are paid as quickly and correctly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: _____ **Your State ID number**, if any: _____

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, stop here

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you
☐ Someone else in your home ☐ Someone else not in your home

Instructions: Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Vision ☐ Dental
☐ Medicare Supplement (Medicare and Medicare Advantage plans do not need to be reported.)

*Policyholder (Last Name, First Name, Middle Initial)		Phone Number ( )
Mailing Address (House #, Street, Apt, *or* PO Box, City, State, Zip)		
*Social Security Number	*Date of Birth	*State ID Number
*Insurance Company Name		Phone Number ( )
Insurance claims office mailing address (#, Street, *or* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy Number	Group Number	Date Policy is Effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Vision ☐ Dental

☐ Medicare Supplement (Medicare and Medicare Advantage plans do not need to be reported.)

*Policyholder (Last Name, First Name, Middle Initial)		Phone Number ( )
Mailing Address (House #, Street, Apt, *or* PO Box, City, State, Zip)		
*Social Security Number	*Date of Birth	*State ID Number
*Insurance Company Name		Phone Number ( )
Insurance claims office mailing address (#, Street, *or* PO Box, City, State, Zip)		
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Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.