

Mid-America Associates, Inc.
560 Kirts Blvd Suite 125
Troy MI 48084

ELIGIBILITY QUESTIONNAIRE

Employee Name _____

Member Number _____

Group Name / Number _____

Dependent Name _____

Is this your:

a. Natural Child? _____

b. Step Child: _____

c. Other, please explain: _____

***If this child has a last name that is different than your own, explain why on line c.
and submit a copy of the child's birth certificate.***

Does anyone else cover this child as a dependent for medical or dental coverage (natural parent or step-parent)? YES ____ NO ____

If yes, list the individuals name and relationship to the child

Who does this child reside with? _____ Relationship _____

What type of other coverage does the child have? MEDICAL _____ DENTAL _____

Who provides **PRIMARY** insurance coverage for this child? _____

ON OCCASION, ADDITIONAL INFORMATION MAY BE REQUESTED

To the best of my knowledge, the above information is true and correct.

Signature of Employee

Date

Please mail to the above address or FAX to: 248-583-4647

