MID AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

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

Fully complete this form and see below to submit.

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