TEAMCARE
A NATIONAL TEAMSTER HEALTH PLAN

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ADULT CHILD OTHER INSURANCE INFORMATION

From time to time TeamCare reconfirms coverage responsibility for the Adult Children of our participants. In order to ensure that claims are properly paid it is important for TeamCare to know if other insurance coverage exists to determine proper primary and secondary responsibility.

- If you have an Adult Child currently covered by TeamCare who now **has other insurance**, please complete this form and return it to the address listed below.
- If you have an Adult Child not currently covered by TeamCare that you wish to add please complete this form and return it to the address listed below.
- Proof of relationship, such as a birth certificate, is required to add an Adult Child reported to TeamCare for the first time.
- You must notify TeamCare of any changes in the Adult Child's insurance status. Overpayments will be applied to your account if insurance status changes and TeamCare is not notified.

PARTICIPANT MUST COMPLETE:

PARTICIPANT'S ID NUMBER (required 9-digit # from medical ID card): 806 _ _ _ _ _ _

PARTICIPANT'S NAME:

I certify the accuracy of the following information and choose to elect coverage on the indicated adult child. I understand that I must inform TeamCare of any changes in their insurance status. I understand that no coverage will be available to this adult child unless an enrollment form is completed and accepted by TeamCare.

Participant Signature:	Date:	Phone:

ADULT CHILD:

Name:

Relationship: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter | Birthdate (mm/dd/yyyy):

Does the Adult Child have other insurance coverage from any of the following:

Adult Child's employment and/or	☐ **YES**	☐ **NO**
Adult Child's spouse's employment (if applicable) and/or	☐ **YES**	☐ **NO**
Adult Child's other parent (if not your spouse) and/or	☐ **YES**	☐ **NO**
Your (Participant) spouse's employment	☐ **YES**	☐ **NO**

►►► If you indicated YES in any box above, please fill in the corresponding information below. ◄◄◄
Attach additional sheets if more than one box is checked YES.

Policyholder Name:			
Employer Name:			
Insurance Carrier Name:		Group Policy Number:	
Effective Date of Coverage:		Insurance Carrier Telephone Number:	

Please complete a separate form for each additional adult child.

Please mail to:
TeamCare
A Central States Health Plan
PO Box 5112
Des Plaines, IL 60017-5112

Fax: (847) 518-9779
Phone: (800) 323-5000
Web: www.MyTeamCare.org