TEAMCARE®
A CENTRAL STATES HEALTH PLAN

ADULT CHILD OTHER INSURANCE INFORMATION FORM

MEMBER NAME:	MBR ID:	8	0	6						
ADDRESS:										
CITY:	STATE:		ZIP CODE:							

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 on Adult Children.

- If you have an Adult Child that you wish to add or whose insurance has changed, 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, unless the child was previously covered by TeamCare.
- 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.

MEMBER MUST COMPLETE:

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 benefits cannot be applied properly for this Adult Child unless this form is completed, returned to TeamCare, and accepted by TeamCare.

MEMBER SIGNATURE:	DATE:	PHONE:

ADULT CHILD:

NAME:	SOCIAL SEC. NO.:
RELATIONSHIP: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter	BIRTHDATE:

CHILD RESIDES WITH: ☐ Father ☐ Mother ☐ Both Natural Parents ☐ Neither Parent

DOES THE ADULT CHILD HAVE OTHER INSURANCE COVERAGE FROM ANY OF THE FOLLOWING:

Adult child's employment:	☐ Yes ☐ No
Adult child's spouse's employment:	☐ Yes ☐ No
Adult child's other parent (if not your spouse):	☐ Yes ☐ No
Your (member) spouse's employment:	☐ Yes ☐ No
Your (member) insurance other than TeamCare:	☐ 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:
POLICYHOLDER DATE OF BIRTH:	CHECK COVERAGES THAT APPLY: ☐ Medical ☐ Dental ☐ Medicare ☐ Medicaid
INSURANCE CARRIER NAME:	GROUP POLICY NUMBER:
COVERAGE EFFECTIVE DATE:	INSURANCE CARRIER TELEPHONE NUMBER:

PLEASE COMPLETE THIS FORM AND RETURN IT TO TEAMCARE AS DIRECTED BELOW.

ONLINE	MAIL	FAX	CALL
Message Center at MyTeamCare.org	TeamCare PO Box 5112 Des Plaines IL 60017-5112	847-518-9784	Questions? 800-TEAMCARE

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