



P.O. Box 211256, Eagan, MN 55121

DEPENDENT/ ADOPTED CHILD FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY
HIOS ID# _____
EC _____

✓CHECK DESIRED ACTION

(FD) Add Dependent
Desired Eff Date _____

(AP) Add Adopted Dependent
Desired Eff Date _____

Please complete this application for Dependent /Adopted child membership
Mail form to: Univera Healthcare P.O. Box 23000, Rochester, NY 14692

SUBSCRIBER INFORMATION – MUST BE COMPLETED Married: Yes No Date of marriage

Social Security # Sex M F Birthdate:

Last Name First Name

Street

City State Zip

Work Phone Number Home Phone Number Cell Phone Number

DEPENDENT INFORMATION – MUST BE COMPLETED

Last Name First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Current Patient of PCP? Yes No Are you a Current Patient of Ob/Gyn? Yes No

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
 Female (See last page for additional information) No

Is child a Foreign Exchange Student? Yes No, If yes, request coverage from to

Is Dependent a full time student? No Yes
If yes, please indicate: Name of School:

OTHER COVERAGE INFORMATION- MUST BE COMPLETED
You may be contacted for additional information. In addition, please provide a copy of your "Certificate of Coverage" from your former dental insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No

If answering "Yes", are you keeping the additional health or dental coverage? Health? Yes No /Dental? Yes No
If No, indicate cancel date- Health Dental

Policyholder's Last Name First Name M.I.

Effective Date: Did this insurance cover Insured Insured and Family

✓ Check previous insurance company from list below and indicate ID #:

(B) UniveraHealthcare

(O) Other - Blue Cross Blue Shield Plan. Indicate Plan Name:

(C) Other Carrier - Indicate Plan Name:

DEPENDENT CHILD - Please complete this section if you are applying for coverage for a child for whom you are the legal guardian or for an adopted child, or a child that has been placed with you for adoption.

Acceptable legal documentation includes:

- For legal guardianship
A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship
- For an adopted child
A copy of court documents signed by a judge showing that the subscriber has adopted the child; or international papers from the country of adoption; or papers from adoption agency showing intent to adopt.

1. Relationship to Subscriber

2. Mother's Last Name First Name

Mailing Address

City State Zip

Date of Birth

3. Father's Last Name First Name

Mailing Address

City State Zip

Date of Birth

Adoption – Inasmuch as I am legally obligated to support this child during the period prior to completion of the adoption proceedings, I hereby apply for the inclusion of this child as a family member under my health plan.

Legal Guardianship- A child for whom the subscriber is the legal guardian is eligible. Please note custody alone is not sufficient. A court must specifically confer legal guardianship. The child is eligible for coverage the date of the court order.

Please submit your acceptable legal documentation along with this form (placement agency papers, letter from law firm/attorney on law firm/attorney letterhead, papers from country of birth).

I hereby certify that on the date (mm/dd/yy) of I began legal proceedings for the adoption of the child noted above.

DEPENDENT – I hereby apply for inclusion of this child as a family member under my health plan. I agree to notify Univera Healthcare when a change in status occurs.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

Subscriber Signature _____ Date _____

**If you have any questions, please contact your Group Representative/Administrator.
Or, visit us at: www.univerahealthcare.com**

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב ביטע רופט 1-800-650-4359, Managed Medicaid מעמבער אדער Child Health Plus איר זענט א מעמבער, ביטע רופט 1-877-626-9298 אלע אנדערע ביטע רופט Essential Plan אויב איר זענט אן 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

Child تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Health Plus أو Managed Medicaid، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid کے ممبر ہیں تو براہ کرم 1-800-650-4359 پر کال کریں۔ اگر آپ Essential Plan کے ممبر ہیں تو براہ کرم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 1-800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.