



Dependent Addition and Change Form for Court-Mandated Health Coverage Complete In Ink - Please Print

☐ Addition ☐ Change (see reverse side)

Form with fields for Group No., Section No., Member Identification No. (Medical), Member Identification No. (Dental), Payroll No., Employee's Last Name (First, Middle), Home Address No. and Street Name, City, State, ZIP, Phone No., Custodial Parent's Last Name (First, Middle), Home Address No. and Street Name, City, State, ZIP, Phone No., State Agency Name, Agency No., Date Employer Received Order, Phone No., State Agency Address No. and Street Name, City, State, ZIP.

Complete all information for each dependent being added.

Effective 1-1-96: Health care companies in Texas are required to follow special procedures in situations where a natural or adoptive parent (or legal guardian) is required by a court to provide health coverage for a child. A copy of the court or administrative order or decree must accompany this form.

Table with 6 columns: List the Full Name of All Dependents To Be Covered (Last, First, Middle), Social Security No., Date of Birth (Mo/Day/Yr), PCP/PCD Name (HMO only), PCP/PCD#, Are You a New Patient? (Yes/No). Includes checkboxes for Son/Daughter.

Previous Coverage Information Complete only if applying for coverage other than HMO or In-Hospital Indemnity

In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.) If Medicare, please complete the Medicare coverage Information Section below.

List names of every individual covered: \_\_\_\_\_

Form with fields for Primary Enrollee (Name, Date of Birth, Male/Female, Relationship to Applicant, Group or Policy Number, ID Number), Employer's Name, Employment Date, Effective Date, Will coverage be continued?, Type of Coverage (Health/Dental), Type of Policy (Self/Family/Employee/Spouse/Child), and Individual Purchase.

Are any of the above dependents covered by any other health or dental coverage? ☐ Yes ☐ No If yes, please check the applicable boxes below and list the effective date for each coverage checked and complete the remainder of this section.

☐ Health ☐ Dental ☐ Group ☐ Individual ☐ Medicare Part A (Hospital) Eff. \_\_\_/\_\_\_/\_\_\_ Eff. \_\_\_/\_\_\_/\_\_\_ ☐ Medicare Part B (Medical) Eff. \_\_\_/\_\_\_/\_\_\_

Please check the reason for Medicare eligibility: ☐ Entitled Disability ☐ End Stage Renal Disease ☐ Disability and Current Renal Disease

Form with fields for Name and Address of Other Health Care Co., ID/Medicare Number, Group or Policy No., Employer's Name, Name of Primary Enrollee, Date of Birth, Male/Female, Relationship To Applicant, Spouse/Dependent.

As a supplement to my previous application, I request the change(s) in coverage to include dependents listed above.

Signature line with fields for Date, Signature, and Relation to Dependent.

Home Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_



Change Form For Court-Mandated Health Coverage Complete In Ink - Please Print

Form with fields for Group No., Section, Member Identification No. (Medical), Member Identification No. (Dental), Payroll No., Employee's Last Name, First, Middle, Home Address No. and Street Name, City, State, ZIP, Phone No., Custodial Parent's Last Name, First, Middle, Home Address No. and Street Name, City, State, ZIP, Phone No., State Agency Name, Agency No., Phone No., State Agency Address No. and Street Name, City, State, ZIP.

Complete all information for the change to each existing dependent

Please check the applicable box(es), show date:

- Cancel dependent coverage, Married, Change of Address - listed above, PCP/PCD Change, Deceased, Other

Table with 6 columns: List The Full Name of All Dependents To Be Covered, Social Security No., Date of Birth Mo /Day/Yr, PCP/PCD Name, PCP/PCD#, Are You a New Patient? (Yes/No). Includes checkboxes for Son/Daughter.

As a supplement to my previous application, I request the change(s) in coverage to include dependents listed above.

Date X Signature Relation to Dependent

Home Phone Number ( )

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hsc.net](mailto:CivilRightsCoordinator@hsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય ચું વી કોઈ બીજી વ્યક્તિને અસુબી.અમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर काल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອນົມກັບນາຍແປພາສາ, ໃຫ້ໃຫ້ທ່ານເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago la'da biká anánílwo'ígíí, na'idílkidgo, ts'ída bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'idílkidígíí bee ní hodoonih. Ata'dahalne'ígíí bich'i'í' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.