



Corporate Systems Administration, Inc.
PO Box 4985
Johnson City, TN 37602
(423) 282-3420
(423) 282-3864 fax

Enrollee:

Dependent:

Soc Sec #:

Group:

Group #:

Location:

Date:

To verify dependent eligibility under the Plan, the following information is required:

1. Is the patient a full-time student? Yes No If yes, please submit a letter from the school's admission office stating the hours and quarters/semesters enrolled.
2. Is the dependent is totally disabled? Yes No If yes, please submit medical documentation detailing the nature of disability.
3. What is patient's relationship to you? _____ Which parent has legal custody? Father Mother
Custodial parent's name _____
4. If our insured is the parent without custody or is the stepparent, is there a court order/decreed that establishes responsibility for health care expenses? Yes No If yes, please submit a copy of the order or decree.
5. Marital status of patient? Single Married
6. Does patient reside with insured? Yes No
7. Is patient employed? Yes No If yes, Full-time or Part-time Hours per week _____.
Does their employer offer insurance? Yes No
8. Is patient financially dependent upon insured? Yes No If yes, to what extent? _____ %

Please be aware any claim will be considered denied unless the requested information is submitted within 30 days of receipt of this notice.

Please sign, date and return this form to: Corporate Systems Administration, Inc.
P.O. Box 4985
Johnson City, TN 37602

Covered Person's Signature: _____

Patient (if other than Covered Person): _____

Patient's (or Parent/Legal Guardian, if applicable) Signature: _____

Dated and Signed this _____ day of _____, _____

Should you have any questions, please contact our Eligibility Department at: (423) 282-3420 or (800) 829-7566.