

ACS Benefit Services, Inc.  
P. O. Box 2000  
Winston-Salem, NC 27102-2000  
Tel: (336) 759-2013, ext. 1264  
Fax: (336) 759-1066

Subscriber Name: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Plan #: SF \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Subscriber ID: (SSN) \_\_\_\_\_

**DEPENDENT CHILD ELIGIBILITY FOR:** \_\_\_\_\_

Action Required by Subscriber: Complete, sign and return this form to ACS.

Your Summary Plan Description states the rules governing dependent eligibility. To ensure that we have the correct information regarding this claimant's dependent eligibility status, please respond to the following questions and return this form to us at the address below. We will be unable to consider any claims submitted for this claimant for payment until we have all necessary information.

1. Is this child principally dependent on you? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is this child living with you? Yes \_\_\_\_\_ No \_\_\_\_\_. If NO, please provide the address at which this child resides and the name of his/her guardian (if applicable):  
Address: \_\_\_\_\_  
Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_
3. Is this child:  Stepchild  Adopted  Placed for Adoption  Foster Child  
 Custody by Court Order (If any item is checked, provide documentation)
4. Are you required to provide Medical and/or Dental coverage on this child by:  
 Court Order  QMCSO (Qualified Medical Child Support Order)  
(If any item is checked, provide documentation)
5. Is this child covered by any other health care coverage? Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, provide the following information about the other health care coverage:  
A. Name of Subscriber/Member: \_\_\_\_\_ SS#: \_\_\_\_\_  
B. Name, address and telephone number for other health care coverage:  
\_\_\_\_\_  
\_\_\_\_\_

The information provided above is complete and true to the best of my knowledge.

Signature: \_\_\_\_\_ (Date) \_\_\_\_\_  
(Subscriber Name)