

**INSURANCE INFORMATION**

Names \_\_\_\_\_ Date \_\_\_\_\_

Please provide us with the following information regarding the health insurance you will use to cover your adopted child.

1. Do you have health insurance? Yes:  No:

2. Is the policy through your employer? Yes:  No:

If so, who is your employer and who is the insured on the policy? \_\_\_\_\_

Does the policy have coverage for your dependents? Yes:  No:

3. Name of carrier \_\_\_\_\_

Address for filing claims \_\_\_\_\_

Claims telephone number \_\_\_\_\_

4. Policy Number \_\_\_\_\_

5. Have you asked your insurance carrier when an adopted child can be covered under your policy? Yes:  No:

If yes, with whom did you talk, and what was their response? \_\_\_\_\_

Do you have a letter confirming that response? Yes:  No:

If yes, please send us a copy of the confirmation.

6. Does your employer have an adoption benefit program? Yes:  No:

If so, please describe \_\_\_\_\_

7. Is there any other information that may be important in dealing with your insurance company? \_\_\_\_\_