SEAFARERS HEALTH AND BENEFITS PLAN

5201 Capital Gateway Drive
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

October 18, 2022

Re: Verification of Dependent(s)

Dear Participant:

So we can better serve all participants, the Seafarers Health and Benefits Plan ("Plan") is updating its records regarding eligible participants. In order to be sure that our records are accurate and up-to-date, please complete the enclosed Dependent Verification Form.

Your completed form must be returned to the Plan by **December 31, 2022. Failure to return your Dependent Verification Form by this deadline will result in the temporary suspension of your dependent's health benefits until your form is received.**

Complete Sections 1 - 3 of the form as they apply to you. In order to verify that your dependent is enrolled in the Plan, you need to sign Section 4 of the form.

For any new enrollments, you must provide a copy of all applicable documents below:

Dependent Spouse	Dependent Child
Marriage Certificate	Birth Certificate
Social Security Card	Social Security Card
	Qualified Medical Child Support Order

Please return the completed form and documents by: e-mail: claimsdept@seafarers.org; fax: (301) 994-0116; or mail: Claims Dept., 45353 Saint Georges Avenue, Piney Point, MD 20694

If you have any questions regarding this notice or the form, contact MAP at (800) 252-4674 (Option 2) or map@seafarers.org. Additional information regarding the Plan can also be found online at www.seafarers.org/plans.

Sincerely,

Margaret R. Bowen
Administrator

SEAFARERS HEALTH AND BENEFITS PLAN

DEPENDENT VERIFICATION FORM

Instructions

This form is for you to verify that your dependent is covered under the Rules of the Plan, or to enroll a dependent in the Plan for the first time.

Fill out the entire form, provide any required documents, and remember to sign and date it. Return your completed form to the Plan by email, fax, or mail.

More information about your benefits, visit us online at www.seafarers.org/plans, which is immediately updated whenever there is a benefit change.

Contact Us

If you need any assistance with the form, contact MAP at map@seafarers.org or (800) 252-4674 (Option 2). Please return your completed form to:

Email: claimsdept@seafarers.org
Fax: (301) 994-0116
Mail: SHBP Claims Department
45353 Saint Georges Avenue
Piney Point, MD 20694

SECTION 1 Participant Information

Full Name:		SSN or ITIN: XXX-XX-	DOB:
Address Line 1:		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)	
Address Line 2:		Cell Phone:	Home Phone:
City:	State: / Zip Code:	Email:	

Required Document(s) for New Dependents

If you select New in Section 2 or Section 3 as the Enrollment Type, you must provide a copy of all applicable document(s) below:

Dependent Spouse	Dependent Child
Marriage Certificate	Birth Certificate
Social Security Card	Social Security Card
	Qualified Medical Child Support Order

Attention: Coordinated Claims

If your dependent has health insurance under another insurer, complete the following and provide a copy of the insured's **Medical ID Card** and **Dental ID Card**:

Health Insurance Provider:	
Insured Name:	DOB:

SECTION 2 Dependent Spouse

Enrollment Type:	Spouse Name:	SSN or ITIN:	DOB:	Gender:
☐ Existing ☐ New		XXX-XX-		

SECTION 3 Dependent Child(ren)

Enrollment Type:	Child Name:	SSN or ITIN:	DOB:	Gender:
☐ Existing ☐ New		XXX-XX-		
☐ Existing ☐ New		XXX-XX-		
☐ Existing ☐ New		XXX-XX-		
☐ Existing ☐ New		XXX-XX-		
☐ Existing ☐ New		XXX-XX-		
☐ Existing ☐ New		XXX-XX-		

SECTION 4 Participant Authorization

I acknowledge that if I fail to immediately notify the Plan of my divorce, I shall be responsible for reimbursing the Plan for all benefits that the Plan erroneously paid to my former spouse and/or child after the date of my divorce, unless there is a Qualified Medical Child Support Order that requires the Plan to pay benefits for the child or the child otherwise qualifies for benefits under the Rules of the Plan.

I understand that I am required to provide a complete copy of my divorce decree to the Plan, and if I fail to reimburse the Plan for benefits that the Plan paid on behalf of my ex-spouse or child because I did not promptly notify the Plan of my divorce the Plan may deduct the amount owed from my future benefits.

I certify that the above information is true and correct and I have provided this information with the understanding the Seafarers Health and Benefits Plan will rely on the information for verification of enrollment under the Rules and Regulations of the Plan.

Participant Signature:	Date Signed: