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: Other Health Insurance Details

Does your spouse or dependent child(ren) under age 26 have health care coverage from another insurer? ☐ Yes ☐ No

If yes, please provide a copy of the insured's Medical ID Card, Dental ID Card, and Divorce Decree, if applicable:

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: