OK Employer Services Center
P.O. Box 248805
Oklahoma City, OK 73124-8805

State of Oklahoma
Oklahoma Department of Human Services
Oklahoma Child Support Services
(405) 522-5550 Oklahoma City Area
(866) 553-2368 Toll Free
(405) 522-5555 Fax Number
www.OKDHS.org

Employer Sequence Number: _____
State Employer ID Number (EIN): _____
Federal Employer ID Number (FEIN): _____

RE: [Employee Name] _____
AP#: [OCSS Identifying Number] _____
SSN: [Employee Social Security Number] _____
DOB: [Employee Date of Birth] _____

We are requesting information about whether medical insurance is/was available to the children of _____ through employment or union membership. This information is being requested pursuant to Federal regulations for the Child Support Enforcement programs at 45 CFR 303.30 and 45 CFR 303.31.

In an effort to comply with Federal law, employers are being requested to provide information concerning the health care for the children of their employees that are receiving child support services from Oklahoma Department of Human Services (OKDHS). When there is any change with regard to employment or insurance coverage for this employee please notify us in writing as soon as possible at the above address.

The back of this form should be completed with the requested information and returned to the address provided within twenty (20) days. Please forward our request to the appropriate department/office if you are unable to complete the requested information. Please send all responses to:

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Oklahoma City, OK 73124-8805

If you have questions concerning this request, contact Child Support at **1-866-553-2368** or **405-522-5550** in the Oklahoma City local area.

Thank you for your time and cooperation.

State of Oklahoma
Oklahoma Department of Human Services
Oklahoma Child Support Services
Employee Medical Insurance Survey

_____ SSN: _____
(Employee Name) NCP NO.: _____

Mailing Address _____
(Street) (City) (State) (ZIP Code)

1. Is this person currently employed by your company? ( )YES ( )NO
If no, please give termination date: _____

Reason: _____

2. Is medical insurance coverage available to you through your company?
( )YES NO( )

3. Are medical benefits being provided under the federal Employee's Retirement Income Security Act (ERISA) of 1974? ( )YES ( )NO

Note: If more than one insurance policy is involved in providing medical coverage, copy this form and complete items 5 through 9 for each insurance company.

4. Medical insurance coverage is available for this employee's
( ) Children ( ) Spouse ( ) Ex-spouse

5. Cost to employee for dependent coverage per pay period is: $ _____
( ) Weekly ( )Bi-Weekly ( )Semi-Monthly ( ) Monthly

<u>Please list the persons currently enrolled</u>

Name DOB SSN
_____ _____ _____

Types of Coverage: (Check all that apply) Medical( ) Dental( ) HMO( )
Prescriptions ( ) Vision ( ) Mental Health ( ) Hospital Surgery ( )
Hospitalization-inpatient ( ) Accidental Coverage ( ) Dread Disease ( )
Hospital ONLY ( ) PPO ( ) Other( )_____

Name of Insurance Company: _____

Policy Number: _____ Group Name _____

Group Policy Number: _____

Policy Holder Name: _____

Policy Holder Social Security Number: _____

Coverage Begin Date: _____ Coverage End Date: _____

Policy Renewal Date: _____

Insurance Policy Deductible Amount: $_____
Name _____

Address _____
City_____ State _____ ZIP_____

Please correct your business information if it is different from the front page.

Employer Name: _____

State Employer ID Number: (EIN) _____
Federal Employer ID Number: (FEIN) _____

Employer Address: _____
(Location Address) City State ZIP

_____
(Delivery Address) City State ZIP

_____
(Print name of person completing form)

_____ _____
(Signature) (Date)

Phone No.( )_____ Fax No.( )_____