

# MONTEREY COUNTY



## DEPARTMENT OF CHILD SUPPORT SERVICES

752 La Guardia Street  
Post Office Box 2059  
Salinas, CA 93902  
[www.co.monterey.ca.us/mcdcscs](http://www.co.monterey.ca.us/mcdcscs)

Phone: 831/755.3200  
Facsimile: 831/796.0232  
TDD: 831/769.9306

Employer Name: \_\_\_\_\_

Date: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Case #: \_\_\_\_\_

Your Employee: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

Child(ren): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear Personnel Director:

The following information is needed to enforce medical support on behalf of the minor child(ren) listed above. You are required to furnish this information pursuant to Family Code Sections 3767 and 17512. Please complete the information below as well as on the attached form, and return it to the Department of Child Support Services within 30 days of the date of this letter.

If you have questions, the number to call is (831) 755-3200. Thank you for your cooperation in this matter.

MONTEREY COUNTY  
DEPARTMENT OF CHILD SUPPORT SERVICES

By: \_\_\_\_\_

### HEALTH INSURANCE STATEMENT

Is health insurance coverage available to member/employee? \_\_\_\_\_, to his/her dependents? \_\_\_\_\_

Member/Employee's policy #: \_\_\_\_\_ Policy Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Are the above named child(ren) currently covered under the health insurance coverage? \_\_\_\_\_

What is the member/employee's monthly cost to cover children on the health plan? \_\_\_\_\_

What is the per child amount to add additional child to health plan? \_\_\_\_\_

Does insurance extend to children residing in the State of \_\_\_\_\_? \_\_\_\_\_ YES \_\_\_\_\_ NO

If child(ren) are currently covered by this employee on a health plan, please complete the attached form. This information is critical for the child(ren) to be able to utilize the health plan coverage. If additional children are covered, attach a separate sheet listing the children and policy numbers.

**EMPLOYEE'S DEPENDENT HEALTH INSURANCE INFORMATION**

Page 1 of 2

TO: DEPARTMENT OF CHILD SUPPORT SERVICES  
P.O. BOX 2059  
SALINAS, CA 93902-2059

Member ID: **0000011622**

FROM:

Employee's Name:  
FLOYD H. GIBBS  
SSN: 530-22-7744

**SECTION I: HEALTH INSURANCE**

EMPLOYEE'S POLICY NO.	POLICY START DATE (Month, Day, Year)	END DATE (Month, Day, Year)
HEALTH INSURANCE COMPANY (for covered dependents)		
INSURANCE COMPANY'S ADDRESS: Street, Unit No. (Address where claims are mailed)		
City, State, Zip Code		PHONE NO: Include Area Code
NAME(S) OF DEPENDENTS COVERED BY HEALTH INSURANCE		DEPENDENT'S POLICY NO.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Check here if names & policy numbers of additional dependents covered by Health Insurance are listed on a separate attached sheet.

The policy covers the following: (Check all that apply)		
<input type="checkbox"/> Doctor Visits	<input type="checkbox"/> Medicare Supplemental	<input type="checkbox"/> Specific Illness
<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hospital Stays	<input type="checkbox"/> Hospital Outpatient (i.e., lab work/physical therapy)	_____

Is Dental included in the Health Insurance?  YES  NO **IF YES, do not complete Section II.**  
Is Vision included in the Health Insurance?  YES  NO **IF YES, do not complete Section III.**

**SECTION II: DENTAL INSURANCE**

EMPLOYEE'S POLICY NO.	POLICY START DATE (Month, Day, Year)	END DATE (Month, Day, Year)
DENTAL INSURANCE COMPANY (for covered dependents)		
INSURANCE COMPANY'S ADDRESS: Street, Unit No. (Address where claims are mailed)		
City, State, Zip Code		PHONE NO: Include Area Code



**SECTION II: DENTAL INSURANCE (CONTINUED)**

NAME(S) OF DEPENDENTS COVERED BY DENTAL INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Check here if names & policy numbers of additional dependents covered by Dental Insurance are listed on a separate attached sheet.

**SECTION III: VISION INSURANCE**

EMPLOYEE'S POLICY NO.	POLICY START DATE <i>(Month, Day, Year)</i>	END DATE <i>(Month, Day, Year)</i>
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VISION INSURANCE COMPANY *(for covered dependents)*

INSURANCE COMPANY'S ADDRESS: *Street, Unit No. (Address where claims are mailed)*

*City, State, Zip Code* | PHONE NO: *Include Area Code*

NAME(S) OF DEPENDENTS COVERED BY VISION INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Check here if names & policy numbers of additional dependents covered by Vision Insurance are listed on a separate attached sheet.

**SECTION IV - (MUST BE COMPLETED)**

- I have enclosed the insurance card(s)/information about the coverage for the children.
- At this time I do not have the insurance card(s)/information about the coverage for the children. I will send the materials to you when I receive it from the insurance company.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_