Iowa Department of Human Services

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: _____ Your State ID number, if any: _____

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, then stop here.

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you

☐ Someone else in your home ☐ Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement

☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

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*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
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Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

For office use only:
County # _____
Worker # _____
Date Rec'd _____