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|  | STATE OF WASHINGTON  DEPARTMENT OF SOCIAL AND HEALTH SERVICES  DIVISION OF CHILD SUPPORT (DCS) | | |
| **Washington State Addendum to Box 2 of Part B - Plan Administrator Response** | | | |
| TO: | | | RE:  SSN:  IV-D CASE NUMBER: |
| EMPLOYER: | | |
| FROM: (Name of Plan Administrator or Employer Representative)  The children listed in ***Part B, Medical Support Notice to Plan Administrator*** are enrolled in the following plan(s).  Send all claims to the names and addresses provided below. | | | |
| **HEALTH INSURANCE PLAN** | | | |
| COMPANY NAME AND ADDRESS | | POLICY NUMBER: | |
| GROUP NUMBER: | |
| TELEPHONE NUMBER: | |
| EFFECTIVE DATE: | |

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| **DENTAL INSURANCE PLAN** | |
| COMPANY NAME AND ADDRESS | POLICY NUMBER: |
| GROUP NUMBER: |
| TELEPHONE NUMBER: |
| EFFECTIVE DATE: |

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| **PRESCRIPTION DRUG INSURANCE PLAN** | |
| COMPANY NAME AND ADDRESS | POLICY NUMBER: |
| GROUP NUMBER: |
| TELEPHONE NUMBER: |
| EFFECTIVE DATE: |

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| **VISION INSURANCE PLAN** | |
| COMPANY NAME AND ADDRESS | POLICY NUMBER: |
| GROUP NUMBER: |
| TELEPHONE NUMBER: |
| EFFECTIVE DATE: |
| Amount of monthly premium required to cover the children: $  **Check the applicable box below.**  ID cards/benefit information:  Will be sent to the children’s custodian.  Will be sent to the Division of Child Support.  Will not be sent. | |