Washington State Department of Social & Health Services
DCS Division of Child Support

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:

EMPLOYER:

IV-D CASE NUMBER:

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:

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

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

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.