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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. |