



NOW YOU CAN AFFORD PEACE OF MIND

Post Office Box 2583  
Atlanta, GA 30301-2583  
877 GA PEACH (427-3224)  
Fax 866-259-3404  
www.peachcare.org

## HEALTH INSURANCE FROM YOUR EMPLOYER

**FAMILY ACCOUNT NUMBER:** \_\_\_\_\_

You must complete this form if you are sending us paystubs, for income verification, that show your family receives any health benefits from an employer. Here is how you can complete this form:

- Write your Family Account Number at the top of each of these two pages.
- Provide information for yourself and everyone in your family. Indicate if each person has private health insurance today and if he or she had it in the past.
- Send all two pages to us.

PeachCare for Kids<sup>®</sup> can sometimes pay bills that your other health insurance doesn't cover. Having insurance that covers only dental or vision does not prevent enrollment in the PeachCare for Kids program.

**For this form to be considered complete, you must fill in every required field and sign and date the certification. We must receive this form within 14 days in order for your child to get health benefits.**

1. Does anyone you are applying for have **other health insurance today**?  Yes  No

If you answered "yes", you must complete questions 2 through 10 and sign and date the certification. If you answered "no", you only need to sign and date the certification.

2. If you answered "Yes", name the Insurance Company/Insurer: \_\_\_\_\_

3. List who is covered and the services they are covered for:

**CHILD # 1:** First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Major Medical  Dental  Drugs (prescription)  Eye Care  COBRA

Long Term Care/Nursing Home  Medicare  Other \_\_\_\_\_

**CHILD # 2:** First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Major Medical  Dental  Drugs (prescription)  Eye Care  COBRA

Long Term Care/Nursing Home  Medicare  Other \_\_\_\_\_

**CHILD # 3:** First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Major Medical  Dental  Drugs (prescription)  Eye Care  COBRA

Long Term Care/Nursing Home  Medicare  Other \_\_\_\_\_

4. Who holds this policy?

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

5. Policy Number: \_\_\_\_\_



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**HEALTH INSURANCE FROM YOUR EMPLOYER - Continuation**

**FAMILY ACCOUNT NUMBER:** \_\_\_\_\_

**6.** Group Number: \_\_\_\_\_

**7.** When did the insurance start? \_\_\_\_/\_\_\_\_/\_\_\_\_

**8.** When will this insurance stop? \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Leave blank if the insurance is not ending)

**9.** Will this health insurance end because the policy holder lost employment?  Yes  No

a. If you answer "No", please explain other reason for loss of coverage:

\_\_\_\_\_

b. If the reason is because "it was too expensive", please tell us what was the monthly cost:

\$\_\_\_\_\_.

**10.** If you answered "Yes" to question 9, please tell us who will lose coverage:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

**How can I send the completed papers?**

By fax: 866-259-3404

Or by Internet: At www.peachcare.org  
From "My Account" select "**Submit Documents**" from the left side of the page.

Or by mail: PeachCare for Kids  
PO Box 2583  
Atlanta, GA 30301-2583

**Certification**

Please sign and date the certification below.

I certify that the information I have provided is true and correct.

\_\_\_\_\_  
**Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

**What if I have questions?**

We can answer your questions. Call us at 877 GA PEACH (427-3224). The call is free.