

## DEPENDENT ELIGIBILITY QUESTIONNAIRE

You have indicated that you have a dependent other than an under-age 19 natural child whom you wish to cover under a Dresser Medical and/or Dental Plan. In order to establish this person's eligibility for coverage, we need the information shown below. You will be advised within 31 days whether or not coverage is approved for this dependent. Please complete this form and return it to:

**Dresser Benefits Administration Group  
15455 Dallas Parkway LB36  
Addison, Texas 75001**

Employee/Retiree Name \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Dependent's Full Name \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship To Employee \_\_\_\_\_ Date Of Birth \_\_\_\_\_

1. Does this child live with you? \_\_\_\_\_ If yes, for how many months of the year? \_\_\_\_\_

Where do the child's natural parents live? (Omit this if you have legally adopted the child).

Father's Name \_\_\_\_\_ Age \_\_\_\_\_  
Complete Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_  
Complete Address \_\_\_\_\_

3. Do you have legal custody of this child? \_\_\_\_\_

4. Who makes the normal parental decisions for this child? \_\_\_\_\_

9. Who is financially responsible for this child?  
\_\_\_\_\_

9. When did this child become your dependent?  
\_\_\_\_\_

7. If over age 18, what school does this child attend? \_\_\_\_\_

8. If over age 18, is this child employed? \_\_\_\_\_ For how many hours per week? \_\_\_\_\_

9. This dependent is: Single; \_\_\_\_\_ Married; \_\_\_\_\_ Legally Separated; \_\_\_\_\_ Divorced \_\_\_\_\_

**I hereby affirm that the statements above are true and that I will notify Dresser immediately if any of these change. I understand that my dependent does not have coverage under a Dresser Plan until approved by the Benefit Administrator.**

Signature \_\_\_\_\_ Date \_\_\_\_\_