INSURANCE MANAGEMENT SERVICES
(806) 373-5944 • 1-800-687-5944
www.imstpa.com • P.O. Box 15688 • Amarillo Tx 79105

VERIFICATION OF DEPENDENT ELIGIBILITY
(PLEASE COMPLETE IN FULL)

The purpose of this form is to confirm that a spouse or dependent with a different last name from the policyholder meets the eligibility requirements of the health benefit plan. Providing this information ensures accurate enrollment, proper claim processing, and compliance with plan guidelines.

Instructions: Complete required information* and submit form and documentation
By Email: PA@imsm.net **Mail to:** IMS, PO Box 15688, Amarillo TX 79105

1. Employee Information*

IMS Policyholder / Employee Name: _____ Date of Birth: ____/____/____

Employer / Group Name: _____Member ID or last 4 of SSN: _____

Address: _____Phone #: _____ Email: _____

For Dependent Spouses or Dependent Children with different last names, please complete the below.

2. Dependent Spouse or Child Information*

Name: _____Gender: _____ Date of Birth: ____/____/____

Address (If different): _____Phone #: _____Email: _____

3. Dependent Spouse or Child Information*

Name: _____Gender: _____ Date of Birth: ____/____/____

Address (If different): _____Phone #: _____Email: _____

For additional children, please provide required information on the back of this form.

Supporting documentation such as: **birth certificates, government-issued marriage license/certificate, full divorce decree and/or child support/custody order, adoption records** must be received within 30 days. Until received, we are unable to process and allow claim submissions for this dependent. If claims are denied, they can only be reconsidered through a written appeal.

If you or your dependent(s) have Other Insurance coverage, please complete a Claim Form available at www.IMSTPA.com/OnlineForms or you may request one by emailing a Participant Advocate at PA@imsm.net.

I represent that the above answers and statements are true and complete to the best of my knowledge. I understand that the statements made will be used to verify that the listed dependent is eligible for coverage in accordance with the definition of the dependent as stated in the health benefit plan under which I am covered.

Employee Signature: _____ **Date**: ____/____/____