HEALTH COVERAGE RESPONSIBILITY FORM

P.O. Box 300019 Kansas City, MO 64130
P#: (816) 531-0334 F#: (816) 753-7252

Date: _____

Member Name: _____

Mo-Kan ID Number: _____

Social Security Number: _____

I, _____ (Social Security Number) _____am the natural parent of the below referenced child.

I do ☐ or will ☐ claim this child on my Income Taxes and I am solely responsible for maintaining health coverage on this child.

Name of Child: _____

Social Security Number: _____

Date of Birth: _____

_____ _____
Responsible Party Signature Print Name

_____ _____
Member Signature Print Name

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal the day and year last above written.

_____
Notary Public

_____
Typed or Printed Name of Notary

_____
My commission Expires: