SB 123 Supervising Officer Insurance Verification Form

Offender Name _____ Offender KDOC # _____

☐ Offender has health insurance coverage.

Please provide all requested information:

Insurance Provider Name: _____

Insurance Provider Address: _____

Member Identification Number: _____

Benefit Plan Name and/or Number: _____

Effective Date of Current Plan: _____

Expiration Date of Current Plan: _____

Please attach a photocopy of the offender's applicable insurance card or other documentation of insurance coverage.

☐ Offender does not have health insurance coverage.

If checking this box, offender must attest to the following statement:

I, _____ (offender's name), do hereby affirm that I am not currently covered by a health insurance, Medicaid or any other health benefit plan. I understand that failure to truthfully notify my supervising officer of any existing health insurance coverage at this time or any other time while receiving certified drug abuse treatment pursuant to K.S.A. 2012 Supp. 21-6824, and amendments thereto, shall constitute a violation of the terms of such drug treatment program and may result in sanctions as provided by law, including, but not limited to, revocation from probation.

_____ _____ _____ _____

(Supervising Officer) (Date) (Offender) (Date)

This form must be completed, signed and submitted to the Kansas Sentencing Commission: 1) at the initial meeting with the offender, and 2) not later than January 31 of each subsequent calendar year.

Vers. 12/2013