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## CHILD SUPPORT

### A. General Information

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's DOB: \_\_\_\_\_ Applicant's SSN: \_\_\_\_\_

Applicant's Driver's License #: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

Applicant's Physical Location (if different):

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### B. Coverage Intentions

Please provide a written outline of why you are purchasing this coverage: \_\_\_\_\_

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### C. Employment

Please outline any knowledge you have surrounding potential future employment: \_\_\_\_\_

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### D. Child Support Order *(a copy of the entire child support order must be submitted to EIB prior to monthly child support obligation payment(s) to be paid pursuant to a valid claim(s))*

1. Please provide the following information:

Case Number: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Monthly Support Payment Ordered: \_\_\_\_\_ Number of Children it applies to: \_\_\_\_\_

Name of Agency/Person receiving child support payments: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

Is there a Case Manager?  Yes  No

Email: \_\_\_\_\_ Office Number: \_\_\_\_\_

Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

**E. Employment Details (\*to qualify for Child Support Insurance the obligor is required to have been continuously employed for 6 months prior to application date)**

**1. Current Employer(s):**

*Beginning/Ending*

Date (MM/YY): \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Position(s) Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

*Beginning/Ending*

Date (MM/YY): \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Position(s) Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

**2. Past Employer(s):**

*Beginning/Ending*

Date (MM/YY): \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Position(s) Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Reason for Termination: \_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

*Beginning/Ending*

Date (MM/YY): \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Position(s) Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Reason for Termination: \_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

*Beginning/Ending*

Date (MM/YY): \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Position(s) Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Reason for Termination: \_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

#### F. Child Support History

1. Are you current on all child support obligations?  Yes  No  
If no, how much do you owe? \_\_\_\_\_

2. Have you ever owed back child support?  Yes  No  
If yes, please provide the dates \_\_\_\_\_, amount \_\_\_\_\_,  
and reason for back child support \_\_\_\_\_

#### G. Personal Information Release form (*please submit 2 original copies*). You must submit a release form approved by the state court that has jurisdiction over the child support case prior to monthly child support obligation payment(s) being paid pursuant to a valid claim(s).

#### REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name