Dependent Child Eligibility Form

(For children 19-25 years old)

An unmarried dependent child age 19-25 must: Be dependent on policy holder for support, AND be living in the household of the policyholder, Or be a full time or part time student.

EMPLOYEE/RETIREE NAME (LAST, FIRST):	EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER:		
ADDRESS (FULL ADDRESS):	CITY:	STATE:	ZIPCODE:

DEPENDENT INFORMATION

DEPENDENT NAME (LAST, FIRST):	DATE OF BIRTH:	AGE:
DEPENDENT SOCIAL SECURITY NUMBER:	GENDER: MALE ☐ FEMALE ☐	RELATIONSHIP TO EMPLOYEE/RETIREE:

Question	Answer
Do you claim this dependent on your taxes?	YES ☐ NO ☐
Is this dependent employed?	YES ☐ Name of Employer:________________ NO ☐
If yes, are insurance benefits available through dependent employment?	YES ☐ NO ☐
Is this dependent enrolled by other medical plan?	YES ☐ NO ☐
If yes, what is the name and address of the medical plan?	Name:______________________________________ Address:____________________________________
This dependent's status is:	Single ☐ Divorced ☐ Married ☐ Separated ☐
Is this dependent a full time student? If **YES** attach full time student schedule; if **NO** continue to next question	YES ☐ NO ☐
Is this dependent, dependent on the policy holder for support and living in the household of the policy holder? If **YES** attach proof of dependency (most current tax return), AND proof of residence (dependent's current drivers license)	YES ☐ NO ☐
Is this dependent a part time student? If **YES** attach proof of part time student status.	YES ☐ NO ☐

I certify that the information above is true and complete. I understand that any changes to this child's status must be reported to the benefit office within 30 days of the change. I authorize the educational institution, employers and medical plans listed above to release enrollment and eligibility status of my dependent child.

Employee/Retiree signature:____ Date: ______________