

******For office use only******

Contract Number: _____ **Group/Division Number:** _____ **PSR Clerk Code:** _____

VERIFICATION OF ELIGIBILITY FOR CERTAIN DEPENDENT CHILDREN

The limiting age and satisfaction requirements for a dependent child are set forth in the contract issued to your employer by Capital Health Plan (CHP). If a claim is denied, it is the subscriber's sole responsibility to establish that the child meets the requirements for continued eligibility. **Additionally, CHP may request documentation to ensure that a child meets and continues to meet eligibility requirements.** This eligibility provision does not modify any other eligibility requirements. (Please refer to your *Certificate of Coverage* or *Member Handbook* for more information.)

A dependent child may be allowed to remain covered provided the child meets the following requirements:

The child is dependent on the subscriber for support; AND

- The child is living in the household of the subscriber, and/or
- The child is a full-time or part-time student (you must refer to your *Certificate of Coverage* or *Member Handbook* for group specific student status criteria)

PLEASE NOTE: The child **must** be dependent for support on the subscriber and meet all the criteria specified in the group contract as described in your Certificate of Coverage or Member Handbook. If the dependent child fails to meet these requirements, the eligibility will terminate.

DEPENDENT VERIFICATION FORM

Based on the above dependent criteria, please provide the following information for each dependent child listed below who is attaining or exceeding the age of 19 by the end of this calendar year ([insert year]) and currently is enrolled in your health plan. Please do not use this form to add dependents into your plan. For additions, you must contact your Group Administrator.

| Relation to me: Indicate if son or daughter. If other, please explain | Dependent's Name | Social Security Number (If not listed, please provide. If incorrect, please indicate correct number.) | Date of Birth (If incorrect, please indicate correct date.) | | | Supported by you? (MUST BE COMPLETED) | | If dependent is supported by you, this section must be completed. Indicate appropriate response (YES or NO) under each column. | | | | | | | | |
|---|------------------|---|---|----|----|---|----|--|----|-----------|----|-----------|----|--------------|----|--|
| | | | | | | | | Living with you | | Student | | | | *Handicapped | | |
| | | | | | | | | YES | NO | Full Time | | Part Time | | YES | NO | |
| | | | MM | DD | YY | YES | NO | YES | NO | YES | NO | YES | NO | YES | NO | |
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THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE

I represent that the statements on this form are true and complete and I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage/membership.

Employee Signature: _____ Social Security Number: _____ Date: _____

***INCAPACITATED OR HANDICAPPED DEPENDENTS:** Please attach a statement from the dependent's physician certifying that the dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and is chiefly dependent on the subscriber for support and maintenance. (Please refer to your *Certificate of Coverage* or *Member Handbook* for more information.)

IMPORTANT NOTICE FOR COBRA/FHICCA CONTINUANTS: If you and your dependents currently are continuing health care coverage through COBRA/FHICCA, you must adhere to the guidelines concerning enrollment verification required by the COBRA/FHICCA Administrator for your group health plan. Please contact your COBRA/FHICCA Administrator for details.