Reset Form

Adult Dependent Enrollment

Please type or print clearly. Coverage will not be processed or may be delayed for failure to return this enrollment form or due to inaccurate, incomplete, or illegible information provided.

Complete one form for each adult dependent child. This coverage applies to all adult dependents under age 26. All coverage by the plan ceases as of the last day of the month in which the adult dependent attains age 26. Please return your completed forms in the enclosed envelope.

Section 1: Information on the Adult Dependent you wish to add back to the Plan's coverage

Social Security Number: _____ Sex ☐ M ☐ F

Last Name _____ First Name _____

Street Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

_____

_____

Home Phone ( ) _____

Date of Birth _____

Father: _____ Mother: _____

☐ Natural Parent	☐ Natural Parent
☐ Adoptive Parent	☐ Adoptive Parent
☐ Foster Parent	☐ Foster Parent
☐ Step Parent	☐ Step Parent
☐ Other	☐ Other

If you check other for either parent, please explain: _____

_____

PLEASE PROVIDE A COPY OF THE ADULT DEPENDENT'S BIRTH CERTIFICATE, ADOPTION DECREE, COURT ORDERED SUPPORT DOCUMENTATION OR ANY DOCUMENTATION THAT SUPPORTS THE ABOVE INDICATED STATUS.

Section 2: PARTICIPANT AND ADULT DEPENDENT VERIFICATION

By signing this form, Participant & Adult Dependent each declare that the information provided for enrollment of a adult dependent is true, complete, and correct. If it isn't, or if the information is not updated and causes benefits to be paid which are otherwise not payable, the Participant and/or the Adult Dependent (individually and jointly liable) must repay any claims paid by the health plan(s) and the Adult Dependent shall lose medical benefits as of the last day of the month he or she qualified.

We understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime and can result in imprisonment, fines, denial of medical benefits, and loss of job.

Submission of this form does not mean that the Adult Dependent will automatically be enrolled in Plan coverage. The Plan will verify eligibility for the Adult Dependent. WE WILL CONTACT YOU IF ENROLLMENT IS DENIED.

_____ _____

Participant signature Date

_____ _____

Adult Dependent Signature Date