

CERTIFICATION OF DEPENDENT ELIGIBILITY

To Be Completed By Plan Member:

PLAN MEMBER'S NAME	ID NO.
ADDRESS	
CHILD'S NAME	DATE OF BIRTH (MONTH, DAY, YEAR)

- This is my natural child.
- This is my stepchild since: _____.
- This is my legally adopted child.
- This is my foster child who is unmarried, under 19 years old and living in a relationship having all the characteristics of a parent-child relationship other than being the natural child and it is expected that I shall continue to rear the child to adulthood. **(Please submit written documentation or other evidence of a bona fide foster child relationship setting forth all relevant aspects of the relationship.)**

I hereby certify that all the information given above is true and complete, and I recognize that the claims processing contractor shall rely upon this information as a material inducement for the coverage of said child under the certificate issued to the undersigned. I understand that a false statement or false representation of fact will result in the termination of my coverage.

Signature of Plan Member

Date Signed

YOU WILL BE NOTIFIED IF YOUR DEPENDENT IS NOT ELIGIBLE.

