Dependent Eligibility Certification Form

General Information

Member Name:	Group Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member SS#:	

Student Certification

1. Name of school in which dependent is enrolled: ____________________
2. Address of school: ____________________
3. Telephone # of school: ____________________
4. Expected date of graduation (if this year): ___/___/___
   mm / dd / yy
5. Student ID#: ____________________

Adult Dependent Certification

Is your dependent child:

1. ☐ YES ☐ NO under age 30?
2. ☐ YES ☐ NO unmarried?
3. ☐ YES ☐ NO insured by or eligible for health insurance through his or her employer?
4. ☐ YES ☐ NO lives, works, or resides in New York State?
5. ☐ YES ☐ NO covered under Medicare?

Disability Certification

1. Is dependent now incapable of self –support because of a disability? ☐ YES ☐ NO
2. Age of dependent when disability occurred: __________
3. Nature of disability (Please provide as much detail as possible):
   ____
   ____
4. Prognosis (estimate months or years): ____________________
5. Name and address of Primary Care Physician: ____________________
   ____
   ____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUEST IN REGARD TO THE CERTIFICATION.

____________________ Member Signature

____________________ Date Signed

Any person who includes any false or misleading information on an application for insurance commits a fraudulent insurance act and is subject to criminal and civil penalties.

Please complete and return the dependent certification form in the envelope provided.