

VERIFICATION OF ELIGIBILITY FOR CERTAIN DEPENDENT CHILDREN

The limiting age and satisfaction requirements for a dependent child is set forth in the contract issued to your employer by Blue Cross & Blue Shield of Florida, Inc. or Health Options, Inc. (BCBSF/HOI). **BCBSF/HOI may request documentation to ensure that a child meets and continues to meet such requirements.** This eligibility provision does not modify any other eligibility requirements. (Please refer to your *Certificate of Coverage, Benefit Booklet, or Member Handbook*, including any *Endorsements*, for more information.)

CRITERIA FOR DEPENDENTS AGES 19-25

A dependent child (age 19-25) may be allowed to remain covered provided the child meets the following requirements:

The child is dependent upon the certificate holder for support; AND

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

Based upon the above dependent criteria, please place a check mark in column 5, next to the dependent child(ren) that **NO LONGER** meet the criteria. (Please refer to your *Certificate of Coverage, Benefit Booklet, or Member Handbook*, including any *Endorsements* for more information.)

Please do **not** use this form to add dependents into your plan. For additions you must contact your Group Administrator.

1	2	3	4	5
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.)	Dependent does not meet eligibility criteria for ages 19-25 . Please terminate effective 12/31/2009.
	First, Middle, Last Name will be listed by BCBSF	SSN (if known) will be listed by BCBSF	DOB (if known) will be listed by BCBSF	
<u>Example 1:</u> Daughter	Jane I. Doe	123-45-6789	01/01/1989	Criteria met : leave blank
<u>Example 2:</u> Daughter	Jane I. Doe	123-45-6789	01/01/1989	If criteria is <u>NO LONGER</u> met, enter ✓

THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE

I represent that the statements on this form are true and complete. I understand that the dependent/dependents that no longer meet all the criteria specified in the group contract as described in my Certificate of Coverage, Endorsements, or Member Handbook, will terminate coverage/membership.

Employee Signature _____
 Contract Number or Social Security Number _____ Date _____

IMPORTANT!

This form should only be returned if the dependent child (ren) does not meet eligibility and is being terminated.

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 upon the certificate holder for support and maintenance. (Please refer to you *Certificate of Coverage, Benefit Booklet or Member Handbook* for more information.)

IMPORTANT NOTICE FOR COBRA/FHICCA CONTINUANTS: If you and your dependents are currently continuing health 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.