UC-103.5A

ACT 4 OF 2009
HEALTH INSURANCE COVERAGE FOR ADULT CHILDREN
DEPENDENT VERIFICATION

Date:

Covered Employee Name: _____ Group Number:_____

Identification Number:_____

Dependent Name: _____ Birthdate: _____

Identification Number: _____

Relationship to Covered Employee: _____

This form must be completed to continue to provide health care coverage for an adult child who no longer qualifies under the terms of the group's insurance contract as a part of the family coverage.

Importantly, upon enrollment in this coverage, all deductibles, out-of-pocket amounts, visit limits and maximums will be reset, even if the adult child enrolls in this coverage in the middle of the benefit period and has previously incurred expenses while enrolled in the family coverage.
To be eligible for extended coverage up to the age of 30, the response to the following three questions must be "no":

1. Is the dependent married? □ YES □ NO
2. Does the dependent have dependents? □ YES □ NO
3. Is the dependent offered/provided private insurance or enrolled in, or eligible for government benefits? □ YES □ NO

Additionally, the adult child must respond "yes" to one of the following questions:

4a Is the dependent a resident of Pennsylvania? □ YES □ NO

4b If not a resident of Pennsylvania, is the dependent a full time student[1] at an institution of higher education? □ YES □ NO

1 For the purposes of this Dependent Verification Form, full time student includes any individual who, pursuant to a federal law known as Michelle's Law, was a full time student, but within the past 12 months has taken a medically necessary leave of absence, or had another change in enrollment, due to a serious illness or injury. The adult child must have been covered under the group's insurance contract as part of the family coverage immediately prior to enrolling in this coverage. Additional information will be required to enroll an adult child who is on a Michelle's Law leave of absence.

I hereby certify that the information given in this form is true and correct. I understand that false statements made herein or fraudulent claims made hereunder are subject to the penalties of 18 Pa. C.S.A. § 4117 relating to insurance fraud.

_____ _____
Employee Signature Authorized Employer Signature

_____ _____
Date Date