Contract Number: **Group/Division Number: 45380** **SA Clerk Code:**

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

Please complete the following. 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			6
Relation to me: Indicate if son or daughter. If other, please explain.	Dependent's Name	Social Security Number	Date of Birth	Supported by you? (*Handicapped =HD) Yes No HD			Dependent does not meet eligibility criteria for ages 19-25. Please terminate.

CRITERIA FOR DEPENDENTS AGES 26-30

A dependent child (ages 26-30) may be allowed to remain covered provided the child meets the following requirements:

- **Unmarried with no dependents of their own AND**
- A resident of Florida OR 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*). AND
- **Otherwise uninsured and not entitled to Medicare**

Please complete the following. 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	Date of Birth	Dependent does not meet eligibility criteria for ages 26-30. Please terminate.

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_______________

*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 your *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 care 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.

If your child is not a full-time or part-time student due to a medical leave of absence, your child is still recognized as an active (full-time or part-time) student.