

## Adult Dependent Election and Eligibility Form

### For Use When Group Subscriber Exercises Mandatory Right of Election to Extend Eligible Dependent Coverage through Age 29

Subscribers covered under group health insurance policies issued in New York State, and their eligible dependents, may purchase extended coverage for dependent children through age 29. To qualify for the extended dependent coverage, the dependent must meet each of the eligibility requirements listed below. This extended coverage is available for new plans issued on and after September 1, 2009 and for existing plans upon the policy's annual renewal date on or after September 1, 2009.

**By completing this form, the undersigned subscriber is electing this continuation of coverage for his or her eligible dependent. The dependent coverage will be the same that applies to the subscriber under the current group policy. The additional premium due with respect to the extended dependent coverage is solely the responsibility of the subscriber.**

#### DIRECTIONS:

Provide the following information in full and submit the signed form with the first premium payment to your employer. In all cases, an Enrollment/Change Form signed by the subscriber is also required to enroll the dependent.

#### MEMBER AND GROUP INFORMATION

Member Name \_\_\_\_\_

Member Identification Number \_\_\_\_\_

Group Name \_\_\_\_\_

Group Identification Number \_\_\_\_\_

#### DEPENDENT INFORMATION

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

MI \_\_\_\_\_

Date of Birth (xx/xx/xxxx) \_\_\_\_\_

Dependent Address \_\_\_\_\_

#### ELIGIBILITY REQUIREMENTS:

The Subscriber Must Answer YES to EACH of the Following Statements for the Dependent to Qualify:

The dependent:

Is the unmarried child of the employee or member/subscriber insured under the policy. \_\_\_\_\_ YES

Is under age 30. \_\_\_\_\_ YES

Is not covered by, or eligible for, employer-sponsored insurance, or a self-insured employer plan. \_\_\_\_\_ YES

Lives, works or resides in New York State or in the plan's service area. \_\_\_\_\_ YES

-- PLEASE SEE OTHER SIDE --

**ACKNOWLEDGEMENT OF PREMIUM PAYMENT OBLIGATION**

I, as the subscriber, understand and agree that I will be fully responsible for payment of the additional premium due with respect to the extended dependent coverage being requested hereby, which may not exceed 100% of the single premium rate.

I, as the subscriber, hereby certify that I am eligible for coverage under the group policy listed above as an employee or member of the group.

**I hereby certify that the above statements regarding eligibility for myself and my dependent are complete and correct to the best of my knowledge.**

*I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

\_\_\_\_\_  
Signature of Subscriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**Please send the completed forms and premium check to Your Employer.**