Contract Number: _____ **Group/Division Number:** _____ **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)

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	Date of Birth	Dependent does not meet eligibility criteria for ages 19-25. Please terminate effective 12/31/2008.
				☐
				☐
				☐

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_____

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 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

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