

**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 3 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<sup>1</sup> at an institution of higher education?  YES  NO

<sup>1</sup>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