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APPLICATION FOR EXTENDED DEPENDENT COVERAGE ELIGIBILITY
FOR CHILDREN UP TO AGE 30 UNDER FL LAW 627.6562

Employee Name ___________________________ SSN (or other identifier) ______________________

Telephone Number ____________________________ Email address ______________________________

Please list all of your children who are over the age of 26 and for whom you are requesting extended dependent coverage:

Name DOB/SSN Name DOB/SSN

____ _______________________ _________________

_________________________ _________________ _______________________ _________________

For EACH child listed above who is between the age of 26 and 30:

Is each child unmarried? YES ________NO________

Is each child a resident of Florida? YES ________NO________

Is each child a full or part time student? School: _______________________ YES _______ NO ________

Does any child have a dependent of his or her own? YES _______ NO ________

Is any child provided coverage under any other health insurance policy or individual health benefits plan, or entitled to Social Security benefits? YES ________NO________

I certify that the information provided above is true to the best of my knowledge. I understand that my dependent child(ren) between the ages of 26 and 30 must continue to meet eligibility requirements in order to continue coverage. I further understand that I or my dependent child may be required to pay an additional premium for continued coverage; to provide proof of eligibility and continued eligibility; that coverage may be considered a taxable benefit for my dependent child; and that if my dependent child, between the ages 26 and 30, terminates coverage my dependent child will not be eligible for reinstatement prior to age 30 unless my child has been continually covered by other creditable coverage without a coverage gap of more than 63 days.

I HEREBY REQUEST COVERAGE FOR MY CHILDREN LISTED ABOVE AND EXERCISE MY OPTION TO HAVE MY CHILDREN BETWEEN THE AGES OF 26 AND 30 INSURED.

Signed: ____ Date: _____________________________

FOR PLAN USE ONLY:
REQUEST GRANTED _____ *REQUEST DENIED* ________ *REASON* __________________________________