

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent.

SECTION A: GENERAL INFORMATION <i>(To be completed by Employee)</i>		
1. Name of Employee (print - last, first & middle initial)	2. Contract ID Number (Such as SSN) _____	
3. Employee's Address (number, street, city, state & zip code)		
4. Dependent Name (print - last, first & middle initial)	5. Dependent's Birthdate (mm/dd/year)	
6. Dependent's Relationship to Employee <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	7. Dependent's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	If dependent is married, give date of marriage (mm/dd/year)
8. Is dependent currently covered under employee's medical group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give name of carrier	
9. Is dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> School Vacation Period Only	
SECTION B: STUDENT DEPENDENT CERTIFICATION <i>(To be completed by Employee)</i>		
1. Name of school in which dependent is enrolled	2. Type of school (i.e., college, trade etc.)	
3. Student enrolled <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Post-Graduate _____ Number of Credits	4. Expected graduation or disenrollment date (mm/dd/year)	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.		
_____ Signature of Employee	_____ Date Signed	
SECTION C: DISABLED DEPENDENT CERTIFICATION <i>(To be completed by Physician)</i>		
1. Is dependent now incapable of self-support because of a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Dependent's age when disability occurred	
3. Nature of disability (please provide as much detail as possible)		
4. Prognosis (estimate in months or years)		
5. Name of Primary Care Physician (print or type)	6. Address of Physician (print or type)	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.		
_____ Signature of Physician	_____ Date Signed	
SECTION D: DEPENDENT NO LONGER ELIGIBLE <i>(To be completed by Employee)</i>		
PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.		
I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBLE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.		
_____ Signature of Employee	_____ Ineligible Effective Date	_____ Date Signed