

Dependent Eligibility Form

PLEASE NOTE: If this is your NATURAL child, indicate below, sign this form, and return.

Location ID No.: _____

Today's Date: _____

The following information is submitted in order for:

Name of Child: _____ Relationship to Employee: _____

Date of Birth: _____ Soc. Sec. No.: _____

To be considered for coverage as a dependent of:

Name of Employee: _____ Soc. Sec. No.: _____

Name of Employer: _____

Please note: This form cannot be used to add dependents. Please complete Special Enrollment form.

❶ Do you and/or your spouse have full legal care/guardianship of this child as though he/she were your natural child? Yes No

If NO, please explain. _____

❷ Does this child reside in your home on a full-time basis? Yes No

If NO, please explain. _____

❸ Is this child claimed as a dependent by you for federal income tax purposes? Yes No

If NO, please explain. _____

❹ When did this guardianship begin? _____ Has it been continuous from this date? Yes No

If NO, please explain. _____

☛ I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Employee _____ Date _____

Location Authorized Signature _____ Date _____

Christian Brothers Employee Benefit Services

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