402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 • PHONE: (800)236-7789 • (715)832-5535 • FAX: (715)838-8507

DEPENDENT CHILD ELIGIBILITY

As an employee of ____,
I understand that my employed eligible dependent child may be eligible to enroll for coverage under my employer's Employee Benefit Plan.

x___________________________________ x________________________________
Employee Name Dependent Child's Name

1. Is your dependent child employed?

☐ NO (If no, skip to Question 3.) ☐ YES (If yes, complete the following.)

Employer's Name: ____

Employer's Address: ____

____

2. Does your dependent child have available to them an employer-sponsored health plan other than a group health plan of a parent?

☐ NO (If No, a verification letter from the employer will be needed. Proceed to Question 3) ☐ YES (If yes, complete the following.)

Insurance Name: ____

Group/Policy #: ____

3. I will notify my employer of any changes in my dependent child's employment/ insurance status.

x___________________________________ x___________________________________
Employee Signature Dependent Child's Signature

Date _____ /_____ /_____ Date _____ /_____ /_____