HIVCO CORPORATION

HEALTH PLAN

Young Adult Child Certification Form

1. Last Name of Member /Employee	First Name	MI	2. Plan ID or SSN	3. Gender ☐ Male	☐ Female

4. Street Address	City	State	Zip

5. Date of Birth	6. Home Telephone Number	6a. E-mail Address

7. Member's Employer

8. Is any dependent child currently covered under the Orange Ulster School Districts Health Plan's (OUSDHP) NYS Age 29 Provision or COBRA (paying full premium) and they wish to terminate this coverage to enroll as a dependent under parent's coverage?

Check one: Yes ☐ No ☐ if yes, both enrollee and their dependents must sign below.

YOUNG ADULT CHILD DEPENDENT INFORMATION

If you currently have individual coverage or you have a dependent that was not previously enrolled or your dependent had a lapse in coverage, please complete this form and return to your school district benefits office for processing.

Name of dependent: _____ Relationship:_____

Dependent's Date of Birth:_____ Gender:_____ SSN: _____

Is dependent married? Yes__, No__. If yes, is dependent covered under his/her spouse? Yes___, No___.

Is your dependent employed? Yes__, No__. If yes, name, address and phone # of employer:

_____

If dependent is employed, is health coverage available through the employer? Yes___, No___.

NOTE: If Health Coverage is available through the Employer, dependent is not eligible under the Orange Ulster Plan.

If no, please send a letter from the employer indicating that Health Coverage is not available.

Is other coverage in effect for your dependent through his/her other parent's employer? Yes__, No__. If yes, name, address of insurance carrier._____

CERTIFICATION

I certify that the information I have supplied is true and accurate. Any person who makes a material misstatement of fact or conceals any pertinent information is guilty of a crime, conviction of which may led to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims. Committing fraud and/or misrepresentation to a Group Health Insurer or Plan is a Federal and NYS crime punishable criminally and/or civilly. Please be certain that all information is truthful and accurate.

_____ _____

Enrollee's Signature (Required) Date (Required)

1._____ 2._____ 3._____

Dependent's Signatures (Required if choosing to cancel NYS age 29 Provision or COBRA coverage) Date (Required)

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