



**CHIEF EXECUTIVE OFFICE  
Risk Management Division**

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**CERTIFICATION OF DEPENDENT STATUS ELIGIBILITY**

If you have dependents who fall into one of the five categories listed below, you must complete and submit this form. Please complete all applicable items, then legibly sign and date this certification.

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Employee I.D. #

\_\_\_\_\_  
Employee's Social Security #

\_\_\_\_\_  
Department

(Dependent's Name) \_\_\_\_\_

(Dependent's Date of Birth) \_\_\_\_\_

A dependent of mine, is eligible for health insurance coverage because he/she falls under the category checked below:

- An unmarried child age 19-24 who is an IRS dependent for the current calendar year. For IRS dependent eligibility, refer to page 12 of the IRS p.501 located on the Employee Benefits website under Forms or IRS.gov.
- An unmarried child age 19-25 who is a full time student at an accredited college or university. Verification of enrollment must be provided.
- A child of subscriber, regardless of age, who is wholly dependent upon subscriber for support because of mental retardation or physical handicap incurred prior to age 19 and who is chiefly dependent upon subscriber for support. You must contact your medical provider for information and the appropriate forms.
- (CIRCLE ONE)** Natural, adopted, foster step-children and minor wards under age 19 with different last names than the subscriber, are eligible for benefits under the subscriber's name.

\_\_\_\_\_  
Date of Placement with Subscriber (If applicable)

- A spouse with a different last name is eligible for benefits under the subscriber's name.

\_\_\_\_\_  
Date of Marriage

\_\_\_\_\_  
Married in: City

\_\_\_\_\_  
County

\_\_\_\_\_  
State

I certify that the information provided above is true and accurate to the best of my knowledge. I will notify CEO/Risk Management – Employee Benefits, immediately if the reason qualifying my dependent for coverage, as indicated above, changes. I understand that eligibility may be verified with appropriate schools and agencies: I may be required to provide additional proof of eligibility (ie., Income Tax Form, Marriage Certificate, Court Orders, Adoption Papers) if requested by my health insurance provider. I also understand that providing false information in this Certification may be grounds for retroactive termination to the effective date of coverage from my health insurance provider.

\_\_\_\_\_  
Signature of Subscriber

\_\_\_\_\_  
Date