MOUNTAIN STATE Blue Cross Blue Shield

DEPENDENT AND STUDENT VERIFICATION ELIGIBILITY

West Virginia group insurance law extends the definition of "dependent" to any unmarried child or stepchild of an eligible employee ***if*** that child or stepchild meets the definition of a "qualifying child" or "qualifying relative" under the Internal Revenue Code. The purpose of this letter is to certify that your adult child, who is beyond his/her 19th birthday, is eligible for coverage under your health benefit plan.

Policy holder name _____

Phone number _____ Identification number _____

Group name _____ Group number _____

Dependent's name *(19 or older)* _____ Date of birth _____

Dependent Status:
Please check the appropriate box, complete the corresponding sections, sign on the next page and **return to MSBCBS within 30 days of receip**t.

I. General

1. ( ) Yes ( ) No — Is the individual your natural child, step-child or adopted child? If no, the individual is ineligible – sign and return.
2. ( ) Yes ( ) No — Is the individual single? If no, the individual is ineligible – sign and return. Marriage date:_____
3. — If yes to both 1. and 2. above, complete Questions 4, 5 and 6, as well as Sections II and III as applicable.
4. ( ) Yes ( ) No — Do you provide half of the individual's primary financial support? *(For non-students, please provide a copy of the first two pages of your previous year's tax return as evidence of dependency. Financial information is not needed and can be blacked out.)*
5. ( ) Yes ( ) No — Does the dependent provide more than one-half of his/her support from all sources?
6. ( ) Yes ( ) No — Is dependent covered under any other employer group insurance or pre-payment program?

II. Student

Name of school where dependent is enrolled _____
Address of school _____
School phone number _____ Student ID number *(if applicable)* _____
List type of school. Acceptable accredited educational institutions include: college or university, nursing school, seminary and vocational school. _____
Course of study _____
Dates of present school term _____ **Expected graduation date** _____

III. <u>Disabled</u> *(unlimited age)*

1. ( ) Yes ( ) No Does the disabled individual reside with you?
2. ( ) Yes ( ) No Is the dependent covered by Medicare?

- <u>To be completed by the dependent's physician</u>:

Is dependent presently incapable of self-sustaining employment by reason of:
( ) Mental retardation ( ) Physical handicap
( ) Yes ( ) No Is incapacity congenital?
( ) Yes ( ) No In your opinion, will the dependent ever be capable of self-sustaining employment?
Date of disability _____
Diagnosis of condition causing handicapped status _____

_____

Please use this space for remarks – give as much detail as you think would be helpful: _____

_____

_____

_____

Signature of Physician Date

Attestation / Affidavit:

I understand MSBCBS may require evidence to support this affidavit, including, but not limited to, tax returns, tuition receipts, and cancelled checks, at any time during the year. I agree to provide such information promptly upon request.

I certify that the above information is true and correct to the best of my knowledge, information and belief. I understand that providing false, inaccurate or misleading information could result in recission of coverage, claim denial, and / or legal action against me by Mountain State Blue Cross Blue Shield or my employer. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

_____

Employee Signature Print Name Date

Return to:
Mountain State Blue Cross Blue Shield
Attn: Membership
P O Box 1948
Parkersburg, WV 26102-1948