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**DETAILS**

I am an active employee with insurance ID number

I am the parent/legal guardian of  (The Dependent)

and request for coverage for the calendar year of:

I confirm that the Dependent listed is unmarried, unemployed (or employed part-time), under the age of 30 and is financially dependent upon me for shelter or care.

Print Name

Signature

Date

**NOTE:** Authorization is required annually for dependent children over age 17 and under age 30. Coverage is suspended on 1st of January each year pending receipt of the verification document if not received prior to then. If your Dependent is no longer eligible to remain on your plan, please ensure you contact your Human Resources department to remove the Dependent from your plan and effect a change in premium if applicable.