HEALTH and DENTAL INSURANCE
REQUIRED DOCUMENTATION FOR QUALIFYING CHILD DEPENDENT WHO HAS ATTAINED AT LEAST AGE 19
Complete and submit a separate form for each dependent child.

Name	**Employee/Retiree Number:**
Address	**Department**
City, State Zip	**Telephone Number**

Please check the box that applies to Employee/Retiree:

☐ Employee (Delta Dental PPO, Voluntary VSP)

☐ Non-Medicare Eligible Retiree (Delta Dental PPO)

☐ Medicare Eligible Retiree (Medical and Delta Dental PPO)

RE: Coverage eligibility for:

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Dependent's Name and Date of Birth

The definition of a dependent child is on the reverse side of this form.

In order to establish continued eligibility for your above named dependent child you must reply to ***all three*** of the following questions and return this statement to the Employee Benefits Service Unit.

☐ Yes ☐ No I certify that the above named dependent child (1) will attain at least age 19 as of above birthday, (2) is unmarried, and (3) is a full-time student.

☐ Yes ☐ No I certify that the above named dependent child is not over age 24 as of above birthday.

☐ Yes ☐ No I certify that either parent will claim the above named dependent child on their Federal Tax return.

If you have answered "No" to any of the above questions, please provide a mailing address for the above named dependent to receive COBRA continuation information:

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I have read and understand the information provided on the reverse side of this form that summarizes the eligibility requirements for a dependent child. Further, under penalty of perjury, I certify that the above statements are true and correct.

Signed ______________________________ Date ______________________

QUALIFYING DISABLED CHILD DEPENDENTS

☐ Yes ☐ No I certify that the above named dependent child is over age 19 and was totally and permanently disabled prior to attaining age 19, (You must provide a copy of the health insurance carriers approved application). If you have not received and completed the disabled dependent enrollment application for your insurance provider, please contact this office.

Should you have any questions or require additional information, please do not hesitate to contact the Human Resources Department, Employee Benefits Service Unit at (925) 655-2100.

This form may be faxed to: (925) 655-2199 or emailed to: Benefits@HRD.cccounty.us

SUMMARY OF DEPENDENT CHILD ELIGIBILITY FOR DELTA PREMIER DENTAL INSURANCE

The definition of dependent child includes natural child, step-child, adopted child, child of a qualified domestic partner and any child specified in a Qualified Medical Child Support Order (QMCSO) or similar court order.

Dependent Children may be eligible for dental and/or vision insurance if the following criteria are met:

Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are:

- ✓ Under age 19;
- ✓ Age 19 up to age 24, who are full-time students, dependent upon you for at least 50% of their support, unmarried and living with you;
- ✓ Disabled child who is over age 19, unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attaining of age 19 and is your dependent as defined by the Internal Revenue Service.

A certified copy of the birth certificate or decree of adoption or adoption order is required for a child dependent to be added to your Delta Dental PPO plan. If your child does ***not*** meet the above qualifications, your child is no longer eligible to continue to be enrolled in your Delta Dental PPO plan. COBRA information will be mailed to your child if presently enrolled on your Delta Dental PPO plan.

Note: It is against County Policy for an employee/retiree to enroll ineligible persons as dependents; to do so may subject the employee to disciplinary action as well as the employee/retiree the obligation to reimburse the plan for all costs associated with the delivery of medical, dental or vision services to an ineligible person.