DEPENDENT CHILD VERIFICATION FORM

Definition of "dependent child": For purposes of "The Patient Protection and Affordable Care Act", Public Law 111-148, a dependent child is defined as a child of an eligible employee of the St. Lawrence-Lewis Counties School District Employees Medical Plan, that is under 26 years of age and does not have health insurance coverage available through his or her current employer.

I hereby certify that my natural, adopted, or eligible step-child listed below meets or does not meet the following requirements so as to be eligible to continue health insurance coverage as a "dependent child".

Employee Name:________________________________ Subscriber ID#:__________________

Child Name: ________________________________ Relationship____________________

Address: ________________________________ SS#___________________________

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A. Under 26 years of age Yes_____ No_____ Date of Birth _____/_____/_____

B. Currently Employed Yes_____ No_____ (If No, then proceed to letter D.)

Name, Address and Phone # of Current Employer:

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C. Does child's employer have health insurance coverage available to child?

Yes_____ No_____

If health insurance is not available to your child but is available to other employees, set forth the reasons therefore in the space provided below, together with the name and telephone number of a health insurance contact person for the above stated employer:

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D. Is the above child currently married? Yes_____ No_____

If yes, is the above named child's spouse employed? Yes_____ No_____

Is your child eligible for coverage under their spouse's health insurance plan?

Yes_____ No_____

If the child is not eligible to enroll under their spouse's health insurance plan, why aren't they eligible?

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E. Is this child eligible for health insurance under ANY OTHER health insurance plan?

Yes_____ No______

If yes, name of plan ____

F. Is child a full time student? Yes_____ No______

I agree to promptly advise the St. Lawrence-Lewis Counties School District Employees Medical Plan of the availability of health insurance coverage for my dependent child through his or her employment.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial or termination of coverage for the above named dependent. I also understand that the St. Lawrence-Lewis Counties School District Employees Medical Plan reserves the right to request further information from me concerning the above-named dependent's health insurance eligibility status, and which information I agree to provide in a timely manner.

____ ____________________

Signature Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of claims for each such violation.

Please return this completed form to:
St. Lawrence-Lewis Insurances
P.O. Box 300
Richville, NY 13681