2018 – DEPENDENT ENROLLMENT FORM (Health Benefits)

Use this form to add qualified dependents who are NOT currently enrolled in your medical/dental/vision plan.

Employee Name (Print) Entity						
 Children are: natural children, stepchildren, foster children, legally adopted children, children placed with you for adoption, and children for whom you have been appointed legal guardianship who are under age 26 or; Physically or mentally disabled, regardless of their age, provided they became disabled before age 26 and were eligible for coverage as a dependent at the time they became disabled. 			• Important: It is your responsibility to enroll only your eligible family members. Employees who cover ineligible family members may be subject to disciplinary action, up to and including cancellation of coverage and/or termination of employment. In most cases, employees will also be required to make restitution to AHC.			
policy for 2018	e following children age Health Benefits:	19 through 25, or legal spous	e, who are	NOT curren	tly enrolled on my hea	alth insurance
Please Print:		Relationship			Type of	Date
First Name	Last Name	(Verification Required)	DOB	SSN	Verification *	Received
Please check coverage(s) requested O Medical O Dental O Vision					Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Adventist Healthcare's health plan. Individuals may request	

Date____

Employee Signature _____

enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2018. For more information contact your HR Representative.

^{*} Verification includes: Birth Certificate, Proof of Adoption, Proof of Legal Guardianship, or Marriage Certificate