

ENROLLING DEPENDENTS IN A HEALTH PLAN

If an employee requests family coverage, existing eligible dependents are enrolled at the same time as the employee. This section expands the definition of dependents and provides special instructions regarding dependent coverage.

Who Is Eligible for Coverage

Eligible Dependents

If the employer offers family coverage to eligible employees, the following dependents may enroll:

- spouse
- unmarried dependent child
- unmarried dependent student
- unmarried dependent legal ward under guardianship
- unmarried dependent under a Child Support Court Order
- unmarried disabled dependent child
- child of a covered unmarried dependent
- domestic partner is by rider available to groups with more than 20 employees

Former Spouse

In the event of divorce or legal separation, the employee's former spouse may maintain coverage under the employee's membership only until: the employee is no longer required by the divorce judgment to provide health insurance for the former spouse; or the employee or former spouse remarries. Speak with your Account Executive for more information.

Dependent Qualifying Events

An eligible dependent may enroll as part of the employee's contract as of the:

- new spouse's date of marriage to the employee
- child's date of birth, adoption, or legal guardianship
- date specified in a Child Support Court Order
- date the spouse and/or child involuntarily lost coverage under another health plan
- date the spouse and/or child voluntarily canceled coverage under another health plan due to the termination of an employer's contribution

Please be sure to review what is needed to add dependents on page 3-13.

Open Enrollment Eligibility Policy

Eligible employees and their eligible dependents who did not enroll as of their initial eligibility date may enroll in the employer's group plan as of the employer's open enrollment effective date.

Questions?
Enrollment Hotline
617-246-9966

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Newborn Dependent Children

Coverage for a newborn natural child becomes effective on the child's date of birth, provided the subscriber arranges for a family contract and notifies Blue Cross Blue Shield by completing the *Enrollment and Change Form* not more than 30 days after the child's date of birth.

A subscriber who has a family contract must notify us to add a new dependent to the family contract by completing the *Enrollment and Change Form* not more than one year after the child's birth.

Adopted Dependent Children

A subscriber must enroll legally adopted dependent children under a family contract in order to ensure coverage for the dependent child.

A subscriber who is enrolled under an individual contract must arrange for a family contract by completing the *Enrollment and Change Form* not more than 30 days after the adoption (or placement in the home for the purpose of adoption or the petition to adopt if the child has been residing in the home of the subscriber as a foster child).

A subscriber who has a family contract must notify us to add a new dependent to the family contract by completing the *Enrollment and Change Form* not more than 30 days after the adoption (or placement in the home for the purpose of adoption or the petition to adopt if the child has been residing in the home of the subscriber as a foster child).

Children under 19 who are legally adopted or placed in the home for the purpose of adoption are eligible for coverage under the employee's contract as of the date of adoption or placement. A signed attestation from the adoption agency that identifies the child and verifies the date and basis of placement is required. For **foreign adoption**, if the date of placement with the adopting parent(s) is not noted in the adoption documentation, a copy of the child's passport with a U.S. immigration date stamp is required. Blue Cross Blue Shield of Massachusetts requires a letter from the adoption agency stating the "date of placement for the purpose of adoption."

The effective date of coverage for an adopted child who has not been previously residing with the subscriber will be the date of placement (for the purpose of adoption) in the subscriber's home, by a licensed adoption agency.

The effective date of coverage for an adopted child who has been residing with the subscriber and for whom the subscriber has been receiving foster care payments will be the date the petition to adopt is filed.

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Disabled Dependent Children

The subscriber must make special arrangements for the disabled child to continue coverage under the family contract. Not more than 30 days after the date the child would normally lose eligibility, the subscriber must complete the *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form* and supply us with any medical or other information that we may need to determine if the child is eligible to continue coverage under the subscriber's family contract. We will make the final determination of the child's eligibility for continued coverage. We may conduct periodic reviews to verify the child's continued eligibility as a disabled dependent; these reviews will require a statement from the child's physician.

Disabled dependents are allowed by state law to continue coverage under the parent's health insurance if certain eligibility and medical criteria are met. Review and approval/denial/certification/recertification of coverage for disabled dependents is the responsibility of the BCBSMA Member Underwriting Department. To ensure corporate compliance with state law, disabled dependents may not be added to or removed from any membership without the written approval of the BCBSMA Member Underwriting Department.

The review process involves a determination of the child's eligibility based on the onset of the condition as it relates to the parent's contract limitations for dependent coverage and a review of medical records to determine the child's capability for engaging in self-supporting employment.

If the child is considered an eligible disabled dependent, a determination is made to continue coverage on a permanent (for the duration of the condition and/or the parent's contract) or a temporary basis. Temporary disabled dependent status is recertified on an annual basis.

Make sure the subscriber submits a *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form*.

Domestic Partners and/or Their Dependents

Coverage for domestic partners and their dependents is available as a rider to qualified accounts. Contact your Account Executive for information and eligibility requirements for this option.

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

To Be Completed by the Child's Attending Physician or/and Psychologist

Section II

Patient's height: _____ Ft. _____ In. Patient's weight: _____ Lbs.

Diagnosis: _____
(print or type)

Severity: Mild Moderate Severe

To your knowledge, how long has this disability existed? Since birth Other (indicate date of onset): _____

Is the patient presently under treatment? Yes No

If yes, please describe the nature of the treatment: _____
(print or type)

Please describe the disability at the time of the patient's 19 birthday:

Physically disabled: _____
(print or type)

Psychologically disabled: _____
(print or type)

If the patient is mentally retarded, what is the mental age or I.Q.? M.A. _____ I.Q. _____

Prognosis: _____
(print or type)

Probable future course of treatment and duration: _____
(print or type)

In your professional opinion, is the patient capable of engaging in self-supporting employment? Yes No

If patient is employed, do you know what duties the patient's job requires? Yes No If yes, please describe duties: _____

In your professional opinion, will this patient ever be capable of self-support? Yes No If yes, please indicate when: _____

Remarks: _____
(print or type)

Signature of physician or psychologist: _____ Date: _____

Please Print the Following Information

Full name of physician or psychologist: _____ Tel. No.: _____

Office address: _____

*Request for Retaining Coverage for a
Psychologically or Physically Disabled Dependent Child Form
(Back)*

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Older Dependent Children

Requests to add dependent children to an existing family contract when the child's date of birth or initial eligibility is prior to the effective date of the existing contract require underwriting approval to confirm eligibility, where applicable, and proof of paternity/maternity.

Student Dependent Children

Most group contracts cover student dependents. Please refer to your benefit literature to determine whether student dependents are covered under the contract and until what age that coverage is available. If your company has chosen to offer student dependent coverage (and most companies do because it's a standard benefit), the following applies:

- Dependent student coverage is generally provided to the unmarried children of subscribers or their spouses who are between the ages of 19 and 25 (age requirements may vary by employer group) and remain full-time students at an accredited educational institution.
- An accredited educational institution is defined as an institution certified by an appropriate accrediting agency (located in the state that the school, college, or university resides in). Eligible students include:*

 - High school students
 - Undergraduate students attending college with 12 or more credit hours
 - Graduate students attending college with 12 or more credit hours

If a full-time student is to remain eligible for dependent coverage, we must receive a completed Student Certification Affidavit (please see sample on next page) verifying his/her enrollment at an accredited school during student recertification each fall or upon their 19th birthday. We'll send the form to affected employees approximately three months prior to their dependent's 19th birthday. If we haven't received the affidavit by the month preceding this date, we'll send a notice informing them that their dependent's coverage will end on the dependent's 19th birthday.

If the 19-year-old dependent is eligible to continue coverage, your employees must submit a completed affidavit each year thereafter. We'll send the certification affidavit in September. If we don't receive the form by October 15, coverage will be cancelled on November 1.

Once the Student Certification Affidavit has been received, approved, and processed, Blue Cross Blue Shield of Massachusetts will mail a confirmation letter to your employee regarding dependent eligibility. We will also conduct an audit of 5% of the returned affidavits to help ensure validity.

If you have any questions, please feel free to contact your Account Service Representative.

*Please note that these requirements may vary, and that the school ultimately determines full-time status.

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

This is a sample of the *Student Certification Form*.



STUDENT CERTIFICATION AFFIDAVIT

I hereby certify that John Castello 02-34-5678
(Student Name) (Social Security Number)

03-23-83 is a full time student at
(Date of Birth)

XYZ University (617) 555-0055
(Accredited Educational Institution) (Registrar office's phone number)

Boston MA 02115
(City/Town) (State) (Zip)

Date the Semester begins 9 / 18 / 02

I hereby certify that information provided above is true and accurate. I further agree to inform Blue Cross Blue Shield of Massachusetts immediately of any changes in this information. I understand and agree that the above information will be used to determine whether my dependent is entitled to dependent student health care coverage. If I misrepresent or provide false or incomplete information, my membership may be terminated (including retroactively) at the discretion of Blue Cross and Blue Shield of Massachusetts and / or my employer.

I understand that this signed affidavit must be received by Blue Cross Blue Shield of Massachusetts before any coverage can become effective for my dependent.

Date: 8 / 15 / 02

John Castello
(Subscriber's Signature)

XXA001234567
(BCBS of MA Identification Number)

Please return to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 9145
N. Quincy, MA 02171-9145
Fax Number: (617) 246-9659

Student Certification Form

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Court-Ordered Child Support

Child Support Court Order law requires that any employee's child under a health care support order be covered under the employee's group health plan.

Once enrolled, the child's coverage must be continued until the support order is no longer in effect, or until the child is enrolled under another comparable health plan, or until the employee is no longer eligible for the employer's group plan, or until the child reaches the plan's maximum age limit or marries, whichever comes first.

- At the account's request, if the employee is not enrolled already in the employer's health plan, we will allow the employee and child to enroll as of the date of notification. However, this is not a qualifying event allowing the employee to enroll under individual coverage. The employee will be allowed to enroll only if the child also is enrolled.
- If the employee is enrolled in the employer's managed care health plan and the child does not live within the allowed service area, the child must be allowed to enroll in the plan. This situation does not create a qualifying event for the employee to transfer to another product or coverage. The employee may enroll in another health plan of the employer as of the next open enrollment.

Divorce or Legal Separation

Divorce: A former spouse may continue coverage under the employee's family contract until the former spouse or the employee remarries unless the the divorce document specifies otherwise. When the employee remarries, the former spouse may be enrolled under an individual contract if the divorce document specifies that the employee must continue coverage for the former spouse. **NOTE:** When the employee or the former spouse remarries and the divorce document requires continued coverage for the former spouse, the former spouse may not continue coverage under the employee's family contract even if the employee's new spouse does not wish to be covered under the employee's group plan.

Separation: A spouse may continue coverage under the employee's family contract until a divorce occurs unless the separation agreement specifies otherwise.

Children of Unmarried Dependent Children

Coverage is available for the children of an unmarried dependent child who is enrolled under the subscriber's family contract. Additionally, for managed care plans, the child of the dependent must reside in the plan's service area. See the plan description for a description of the service area. Coverage for the dependent's child will become effective on the child's date of birth, as long as we receive a completed *Enrollment and Change Form* not more than 30 days after the child's date of birth. The dependent of an unmarried dependent child is included as a family member as long as the unmarried dependent child remains eligible.

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

How to Enroll Dependents

To enroll eligible dependents at the time of the subscriber's initial enrollment, simply complete the dependent's information on the *Enrollment and Change Form* (name, address, date of birth, etc.).

Remember: In the **Type of Transaction** section of the *Enrollment and Change Form*, check the "Add" box.

In the **Remarks** section, specify the type of dependent being added, such as: Add newborn, Add spouse, etc.

For **adopted children**, attach court documentation.

For **disabled dependents over age 19**, attach *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form*.

Please note: We encourage you to submit enrollment requests as early as possible. If we receive a notice of a new enrollment to your plan within 30 days of the requested effective date, we will honor that date.

If you do not enroll the new dependent within 30 days of the requested effective date, the member is not eligible to enroll until your next open enrollment period.

Do not enclose enrollment requests with your monthly bill payment. This will delay processing of applications and could affect members' coverage.

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

How to Complete the Enrollment and Change Form

The following example shows how to add a new spouse to an employee's contract due to marriage. Use this example for additions or changes that concern dependents. The employee only needs to fill in the shaded area of section 2, and then either section 3 (if adding a spouse), or section 4 (if adding dependents).

See Section 2, *Enrolling Employees in a Health Plan*, for instructions on completing the *Enrollment and Change Form*.

BlueCross BlueShield of Massachusetts		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
An Independent Licensee of the Blue Cross and Blue Shield Association				Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145	
1. To Be Filled Out by Your Employer					
Company Name ALLEN ELECTRIC COMPANY		Current Medical Group 0012345		Medical Group Transferring To	
Current BCBS ID Number, if any 012345678		Requested Effective Date 02 14 2000	Date of Hire 06 21 1999	Initial Eligibility Date 06 21 1999	Current Dental Group 0012345
Type of Transaction Add <input checked="" type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/>		Remarks: (i.e., qualifying event for a new add, change to family, or further instructions) PLEASE ADD SPOUSE AS OF DATE OF MARRIAGE 2/19/00			
2. Tell Us About Yourself (Member 1)					
What product are you seeking? <input checked="" type="checkbox"/> Health <input checked="" type="checkbox"/> Vision <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Life <input checked="" type="checkbox"/> Accidental Death & Dismemberment <input checked="" type="checkbox"/> Long Term Care <input checked="" type="checkbox"/> Other <input checked="" type="checkbox"/>		Kind of Membership (Medical) Individual <input type="checkbox"/> Family <input checked="" type="checkbox"/>		Kind of Membership (Dental) Individual <input type="checkbox"/> Family <input checked="" type="checkbox"/>	
Your First Name TANYA		M.I. Last Name M KNIGHT		Sex F	Date of Birth 05 01 1969
Street Address / P.O. Box No.		Apt. No.	City/Town	State	Zip Code
Social Security No. 012345678		Home Telephone No. (include area code) (617) 555-1212		Other Insurance Company Name City/State	
Name of PCP City/State		PCP ID Number		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Are you or anyone listed below covered by Medicare? <input checked="" type="checkbox"/>		Part A Effective Date	Part B Effective Date	Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	Actively Working Y / N Retired Y / N. If yes, date
* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name CARLTON		M.I. Spouse's Last Name C KNIGHT		Sex M	Date of Birth 05 12 1968
Social Security No. 012345678		Home Telephone No. (include area code) (617) 555-1212		Other Insurance Company Name City/State	
Name of PCP DR SMITH City/State SALEM MA		PCP ID Number 181 M23450		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>	
Part A Effective Date		Part B Effective Date		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	
				Actively Working <input checked="" type="checkbox"/> Retired Y / N. If yes, date	
4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name		M.I. Child's Last Name		Sex	Full-time student? Age 18 or over Y / N
Date of Birth	Social Security No.	PCP ID Number		Name of PCP	
				Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Child's First Name		M.I. Child's Last Name		Sex	Full-time student? Age 18 or over Y / N
Date of Birth	Social Security No.	PCP ID Number		Name of PCP	
				Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Child's First Name		M.I. Child's Last Name		Sex	Full-time student? Age 18 or over Y / N
Date of Birth	Social Security No.	PCP ID Number		Name of PCP	
				Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.					
Employee's Signature Tanya Knight		Date 2/19/00		Employer's Signature M. Knight	
				Date 2/19/00	

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Student and Dependent Eligibility Report

This report will show you three categories of situations:

1. Dependents nearing the regular dependent maximum age,
2. Students nearing the student dependent maximum age, and/or
3. Students going through the student recertification process. These students will appear on this report up to three times a year – in April, in August, and again in October if the student hasn't responded.

The most common status you'll see here is "regular" meaning a regular dependent or "student." Handicapped dependents will be bypassed by the maximum age process as long as we have approved the member's coverage beyond the maximum age. Thus, they will never appear on this report nor will they receive a letter.

The same member may appear on up to three monthly reports. The first time, the report will show "maximum age letter" sent. The second time, it will show "cancel letter." The third time, it will show "canceled – no letter" to indicate that the actual cancellation has taken place, but no letter was mailed. (See message key, page 3-12.)

Please note: If at any time during the three months, the appropriate action is taken to change the member's status, the member will not appear on subsequent reports.

This section tells you the type of benefits the group has. It could be medical, dental, or both. It also gives the maximum age to which the member is covered for each benefit. Coverage ends on the birthday unless your group has specified otherwise. If that's the case, any variation is spelled out here.

This potential cancellation date is generally three months in the future. At this point, the member is not yet canceled and may avoid cancellation if the appropriate action is taken. (For example, a member nearing age 19 may be a full-time student; once we're notified to switch him/her to a student status, the cancellation will not be processed.)

Blue Cross BlueShield of Massachusetts		BC & BS OF MASSACHUSETTS STUDENT AND DEPENDENT ELIGIBILITY REPORT					PAGE: MONTH ENDING: 04/30/00	
REPORT: MDE AGE TODAY'S DATE: 05/01/00							CBU: ACCOUNT NUMBER: 4000011	
GROUP BILLING UNIT: 006007771-0000		ABC CLEANING SERVICES						
GROUP NAME:								
BENEFITS:								
MEDICAL - DEP TO 19; STU TO 26								
DENTAL - DEP TO 19; STU TO 23								
DEPENDENT SUBSCRIBER NAME/ADDR/PHONE	STATUS OF DEPENDENT	IDENTIFICATION NUMBER	DATE OF BIRTH	BENEFIT GROUPING	BENEFIT CANCEL DATE	LETTER SENT		
THOMAS JONES PATRICIA JONES 300 WINTER ST S BOSTON MA 02110 (617) 376-1258	STEPCHILD	0011201210000 10	08/21/76	MEDICAL DENTAL	08/21/00 08/21/00	DEP MAX AGE LTR		
STEVE C SMITH MARGARET SMITH 313 SCHOOL ST S BOSTON MA 02116-1610 (617) 482-9615	REGULAR	0015867170000 10	08/21/76	DENTAL	08/21/00	DEP MAX AGE LTR		
MICHAEL S CASEY SCOTT CASEY 56 WASHINGTON ST, APT 2 W ROXBURY MA 002138 (617) 326-2519	REGULAR	0114321710000 10	05/07/76	MEDICAL	05/07/00	DEP CANCEL LTR		
KEVIN W KELLEY WILLIAM KELLEY 1021 ASHMONT DRIVE FRAMINGHAM MA 02131-1241 (508) 969-1409	REGULAR	0116521720000 10	04/07/76	MEDICAL	04/07/00	CANCEL - NO LTR		
THERESA C SHERMAN MARY S SHERMAN 56 WASHINGTON ST, APT 2 W ROXBURY MA 002138 (617) 326-2519	STUDENT	0117120130000 10	08/07/72	DENTAL	08/07/00	STU MAX AGE LTR		
SHAWN T CAINES SCOTT CAINES 56 WASHINGTON ST, APT 6 W ROXBURY MA 002138 (617) 326-2009	STUDENT	00143217170000 11	05/10/70	MEDICAL	05/10/00	STU CANCEL LTR		
PAUL M KANE PATRICIA KANE 300 WINTER ST S BOSTON MA 02110 (617) 376-1258	STUDENT	0011201210000 11	07/14/72	MEDICAL DENTAL	11/01/00 11/01/00	UPCOMING RECERT		

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Message Key for Letter Sent Column

UPCOMING RECERT:	Letter mailed to a parent in May advising, if their student is graduating in May, to please let the employer know now. Otherwise, we'll ask student to recertify in September.
STU RECERT FORM:	Letter mailed to a parent in September with the <i>Student Certification Form</i> enclosed. This form must be returned by October 15.
STU RECERT CXL:	Letter mailed to a parent in November if we haven't received their son or daughter's <i>Student Certification Form</i> . The letter states that their student was canceled as of November 1.
DEP MAX AGE LTR:	Letter mailed three months before a regular dependent turns age 19.
DEP CANCEL LTR:	If we've received no response to our first letter, a follow-up letter is mailed approximately one month before the birthday, advising that the dependent will soon be canceled.
STU MAX AGE LTR:	Letter mailed three months before a student dependent turns age 23 or age 25.
STU CANCEL LTR:	If we've received no response to our first letter, a follow-up letter is mailed approximately one month before the birthday, advising that the dependent will soon be canceled.

Type of Contract Adjustment Report

This report is geared toward accounts with more complex financial arrangements. It will alert you to adjust the subscriber's membership if you offer three-tier rates of contract. If the number of members on the contract decreases, you will realize savings on your premium bill if you quickly adjust the membership, or transfer the membership from family to two-party or from two-party to individual.



REPORT: TOCHANGE
TODAY'S DATE: 04/01/00

BC & BS OF MASSACHUSETTS
TYPE OF CONTRACT ADJUSTMENT
REPORT

PAGE:
MONTH ENDING: 03/31/00

GROUP BILLING UNIT: 006007771-0000
GROUP NAME:

ABC CLEANING SERVICES

CBU:
ACCOUNT NUMBER: 4000011
RATE STRUCTURE: 21

MEMBER NAME	MEMBER RELATION	IDENTIFICATION NUMBER		DATE OF BIRTH	CURRENT TYPE OF CONTRACT	CURRENT NUMBER OF MEMBERS	CANCEL DATE
MICHAEL S CASEY	DEPENDENT	0124321710000	10	07/07/76	119-FAMILY	03	07/07/00
SHAWN T CAINES	DEPENDENT	0214321710000	11	07/10/70	119-FAMILY	03	07/10/00
TERRI M CHURCH	SPOUSE	0111431370000	00	06/13/30	127-FAMILY	03	06/01/00

** END OF REPORT **

Call Your Account Service Representative for More Information on This Subject

ENROLLING DEPENDENTS IN A HEALTH PLAN

Enrollment Underwriting

WHAT DO WE NEED TO ENROLL A NEW DEPENDENT?

Completed applications received within 30 days of requested effective date with a qualifying event of:

New Hire – completed and signed application.

Spouse due to Marriage – completed and signed application.

Spouse/dependents due to loss of coverage – completed and signed application and HIPAA certificate.

Newborn on a family plan, or female individual plan – completed and signed application.

Newborn on a male individual plan – completed and signed application and copy of birth certificate proving paternity.

Domestic Partner – completed and signed application (accounts with rider only).

Student Dependent – completed and signed application and copy of confirmed enrollment from registrar or copy of statement showing payment of tuition. *Please note date of the start of the semester must be on document to determine qualifying event date.

Dependent/Spouse coming into the country – completed and signed application and copy of passport with date of entry stamp. Marriage certificate and/or birth certificate.

Adoption – completed and signed application and a signed letter from the adoption agency indicating the exact date of placement.

Dependent by court order – completed and signed application and a copy of the court order.

Please Note: Applications received beyond 30 days of the requested effective date are subject to Underwriting approval. Additional information may also be required. Please contact your Account Service Representative for instructions.

Call Your Account Service Representative for More Information on This Subject