



**OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD
APPLICATION FOR COVERAGE FOR OTHER DEPENDENT CHILDREN**

This form must be completed by a member who is requesting coverage on an unmarried child, other than his or her own daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with the member for adoption, who lives with the member in a parent-child relationship and for whom the member is financially responsible. Documentation of guardianship or the member's most recent income tax return listing the child as a dependent may be provided in lieu of this application. All questions must be answered fully.

New Hire Midyear Option Period

Group ID # _____ Division ID # _____ Group Name _____

Member's Name _____ SSN or Member ID # _____

Member's Address _____ City _____ State _____ Zip _____

Child's full name _____ Birthdate _____

Child's SSN _____ Male Female

1. What is the child's relationship to the member? _____
2. When did the parent-child relationship begin? _____
3. Give date (month/day/year) child entered the home? _____
4. If the child was not claimed on your last tax return, do you intend to claim the child on this year's tax return? _____
If no, explain _____
5. If approved, check the box(s) of coverage you wish the dependent to be enrolled. When one eligible dependent is covered, all eligible dependents must be covered for all elected coverage.
 Health Vision
 Dental Dependent Life * Premier Standard Low (circle one)

Requested effective date _____

*If you have other dependents, this child will be added to the same level of coverage.

I have read before signing, and certify that all information provided above is true and correct, and that failure to provide correct information may result in denial or cancellation of dependent coverage and consequent denial or recoupment of claims payments. I understand that giving false information to obtain insurance is a criminal act defined as fraud under Oklahoma State Statutes, and is punishable by fine and/or imprisonment.

Member's Signature _____ Date _____

FOR BOARD USE ONLY	
____ Approved Eff. Date _____	____ Denied
_____ Authorization Signature	_____ Date

Application for Coverage for Other Dependent Children

The Application for Coverage for Other Dependent Children is required to request health, dental, vision and/or life coverage on any child where the member has not been granted custody, adoption or guardianship by a Court and where the member's most recent income tax return does not list the child as dependent for income tax purposes. (The Application for Coverage for Other Dependent Children is not required if any of these conditions are met or if the dependent is the member's natural child or stepchild. The member should then follow normal OSEEGIB dependent enrollment procedures.)

The member may request dependent coverage on a child who is in his/her home and in which a parent-child relationship exists between the member and child provided the request is made within 30 days of the child entering the home. If coverage is not requested within 30 days, current employees cannot add coverage until the next annual Option Period and benefit limitations may apply. Former employees are not allowed to add coverage at any later date.

The Application for Coverage for Other Dependent Children form must be submitted to and approved by OSEEGIB before any coverage will be allowed on a child where no Court order exists and where the child is not listed on member's most recent income tax return. Coverage, if approved, shall begin on the first day of the month following approval, and will never apply retroactively.

The member must have basic life coverage in order to have any dependent life. All other applicable eligibility requirements must be satisfied and all necessary premiums must be paid.

Note: It is your responsibility to notify your Insurance Coordinator when your child becomes ineligible. Former Employees should notify OSEEGIB in writing. OSEEGIB will not pay claims on ineligible dependents even if you have paid premiums for that dependent. The Plan retains the right to verify the dependent's status, at any time, and to discontinue coverage for any dependent that is found to be ineligible for any reason.

Current Employees should return this form to their Insurance/Benefits Coordinator. Former Employees should return this form directly to OSEEGIB, PO Box 58010, Oklahoma City, OK 73157-8010.