



Office of Management and Enterprise Services
 Employees Group Insurance Department
APPLICATION FOR COVERAGE FOR OTHER DEPENDENT CHILDREN

You must complete this form to request coverage for an unmarried child, other than your own daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption, who lives with you in a parent-child relationship, and for whom you are financially responsible. Documentation of guardianship or your most recent income tax return listing the child as your dependent can 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 Code _____

Child's Full Name _____ Birthdate _____

Child's SSN _____ Male Female

1. What is the child's relationship to you? _____
2. When did the parent-child relationship begin? _____
3. Give date (month/day/year) child entered your 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 _____

If approved, check the box(s) below to indicate the coverages in which you wish the dependent to be enrolled. When one eligible dependent is covered, all eligible dependents must be covered for all elected coverages.

Health Vision Dental
 Dependent Life * Premier Standard Low (circle one)

Requested effective date _____

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

I have read this form 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 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 EGID 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 a child when you have not been granted custody, adoption or guardianship by a Court, and when your most recent income tax return does not list the child as a dependent for income tax purposes. This application is not required if any of these conditions are met or if the dependent is your natural child or stepchild. You should then follow normal EGID dependent enrollment procedures.

You can request dependent coverage on a child who is in your home and a parent-child relationship exists between you and the child. The request must be made within 30 days of the child entering your 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 cannot add coverage at any later date.

The "Application for Coverage for Other Dependent Children" must be submitted to and approved by EGID before any coverage will be allowed for a child when no court order exists and when the child is not listed on your most recent income tax return. Coverage, if approved, shall begin on the first day of the month following approval and will never apply retroactively except in the case of a newborn which shall be added the first [1st] of the month of birth.

You must have Basic Life coverage in order to request 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/benefits coordinator when your child becomes ineligible. Former employees should notify EGID in writing. EGID 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 who 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 EGID, PO Box 58010, Oklahoma City, OK 73157-8010.