



OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD  
 3545 Northwest 58<sup>th</sup> Street, Suite 110, Oklahoma City, Oklahoma 73112  
 1-405-717-8701 or 1-800-543-6044

## DECLARATION OF DEPENDENCY

This form must be completed by a member who is requesting coverage on a child, other than his or her own child or stepchild, who lives with the member in a parent-child relationship and for whom the member is financially responsible but does not have a court order indicating adoption, guardianship, legal separation or divorce and the member's most recent income tax return does not list the child as dependent for income tax purposes. 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. Give date (month/day/year) child entered the home? \_\_\_\_\_
3. 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 \_\_\_\_\_
4. 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 \_\_\_\_\_

<b>FOR BOARD USE ONLY</b>	
_____ Approved      Eff. Date _____	_____ Denied
_____ Authorization Signature	_____ Date

## **Declaration of Dependency Form Requirements**

**The Declaration of Dependency Form 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 Declaration of Dependency form is not required if any of these conditions are met or if dependent is member's natural child or stepchild. Member should then follow normal OSEEGIB dependent enrollment procedures.)**

**Member may request coverage on a child who is in their 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 their home. If coverage is not requested within 30 days of the initial placement, 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 Declaration of Dependency 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, when 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: The Plan retains the right to verify the dependent's status, to request copies of the insured's federal income tax returns from time to time, and to discontinue coverage for any dependent that is found to be ineligible for any reason.**