



North East Independent School District

Benefits Enrollment Form For Dependent(s) Over Age 18

Complete this form to add or continue health, dental, and/or vision coverage for your eligible dependent(s) over age 18. A child between 19 and 24 years of age is considered an eligible dependent if it is your natural child or your legally adopted child, including a child for whom the participant is a party in a suit in which the adoption of the child is sought; or your stepchild whose primary household is your residence; or A child whose primary residence is your household, and to whom you are legal guardian; and IRS support guidelines are met.

Children with permanent disabilities may be eligible to **continue** coverage after they reach 24 years of age. If you are requesting coverage for a disabled child, please submit the **Dependent Child's Statement of Disability** in addition to this form.

Employee Information:	Name: _____ Social Security #: _____ Work Phone: _____ Home Phone: _____ Campus: _____
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Coverage Requested:	(Check all that apply) ___ Health ___ Dental ___ Vision
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Dependents:	1	Name: _____ Sex: ___ Date of Birth: _____ Relationship to Employee: _____ Social Security Number: _____ Full-time Student? ___ Yes ___ No Age: _____
	2	Name: _____ Sex: ___ Date of Birth: _____ Relationship to Employee: _____ Social Security Number: _____ Full-time Student? ___ Yes ___ No Age: _____

Other Insurance:	Complete the following information for any dependent named above that is covered under another group insurance or prepayment program:
Dependent Name(s): _____	
Policy Holder: _____	Insurance Company: _____
Policy Number: _____	Effective Date: _____

Certification

I understand that:

- The information provided in this statement will be used to determine dependent eligibility for insurance under my membership;
- Intentionally providing false information or statements will be grounds for NEISD to void my health, dental, and/or vision plan coverage;
- Eligibility for health, dental and/or vision coverage ends on the date the child is no longer eligible, regardless of when notice is given to NEISD;
- I am responsible for notifying NEISD of the date my child becomes ineligible for health, dental and/or vision coverage because of a change in dependent status (exceeding age limitation or no longer relying upon you to provide at least one-half of his or her support as defined by the Internal Revenue Code of the United States);
- Failure to provide notice within 60 days may jeopardize my child's right to COBRA continuation coverage and may create a liability on my part for claim costs and/or repayment of health/dental care plan premium contributions made on behalf of my child(ren) after eligibility has ended;
- If I opt to place coverage under the Cafeteria Plan, premium deductions for dependent coverage will be paid on a pre-tax basis only until one of my dependents ceases to be a full-time student or reaches the age of 24. At that time, the dependent portion of my premium contribution will be paid with after-tax dollar as mandated by IRS regulations. If I am enrolled in the Cafeteria Plan, I agree to notify the Benefits Office if one of my dependents ceases to be a full-time student or reaches the age of 24.
- **Concerning Child(ren) Other Than Your Natural Child(ren)** If any of the above named dependents are not my natural or legally adopted children, I attest that they meet the following eligibility criteria, based on the relationship listed:

Stepchild(ren): Child(ren) reside in the employee's household and are eligible to be claimed by the employee as dependent for Federal Income Tax purposes.

Other Child(ren): For those other than natural, adopted, or stepchild(ren), the employee is the legal guardian of the child(ren) and the child(ren)'s primary residence is the employee's address and IRS support guidelines are met.

By signing below, I attest that all information provided in this form is true and correct and confirm that I have read and understand the Certification Statement above.

Employee Signature: _____ Date: _____

Office Use Only	Effective Date: _____	Payroll: ___ Monthly ___ Biweekly	By: _____
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