This form is to verify Dependent Eligibility for Recognized Children Only. Please see the Recognized Child Definition Below

UNIVERSITY OF ROCHESTER
HEALTH CARE PLANS and DENTAL PLANS
for FACULTY/STAFF
UNMARRIED RECOGNIZED CHILD ELIGIBILITY VERIFICATION FORM

Eligible Recognized Child is an: Unmarried grandchild, niece, nephew, or other child up to age 24 who lives with you in a parent/child relationship for whom you are the legal guardian, claim as a federal tax dependent and does not have access to other employer health coverage**.**

Employee Name _____ Employee ID # _____
(Please Print)
Employee Phone #_____
Address _____
Recognized Child's Name _____
Recognized Child's Date of Birth _____
Type of Coverage Requested: (*check all that apply*) _____ Health _____ Dental
Recognized Child's Relationship to you: ___ Grandchild ___ Niece ___ Nephew ___ Other Child

Please review the definition of a Recognized Child at the top of this form. Additional details on eligibility are available in the 2011 University Health Care Decision Guide or by contacting the Benefits Office at (585) 275-2084.

I acknowledge and agree that by signing this eligibility verification form and subsequently accepting services, I and each of my family members who are covered under the Plans are bound by the terms and conditions of the plan documents and associated administrative documents that from time to time are in effect and that these documents have been available (and will continue to be available) to me online at www.rochester.edu/benefits or in hard copy at the University of Rochester Benefits Office.

I also acknowledge and agree that by signing this eligibility verification form that I attest I am the legal guardian for the child listed above, claim as a federal tax dependent, and the child does not have access to other employer health coverage.

I understand that my coverage may be cancelled and any claims denied upon one month's written notice, if I have knowingly included false information. I have read and understand the information defining dependent eligibility under the University of Rochester Health and Dental Plans.

Parent's Signature_____
Date_____

Please return this form to the Benefits Office in the University of Rochester Medical Center, Room G-8011, Fax number (585) 273-1054 or Box 636 through intramural mail.

FOR BENEFITS OFFICE USE ONLY

_____ _____
Effective Start Date Effective End Date