

Office Use Only

Application for Sponsored Dependent

This application must accompany the Medical Plan Enrollment Form for your application to be considered complete and for enrollment to take effect.
Not available if your medical benefits coverage is Blue Cross Blue Shield.

Subscriber Information

Name of Employee (Last, First, Middle)	Daytime Phone	Social Security Number
	E-Mail	Banner ID

Sponsored Dependent Information

Name of (Last, First, Middle)	Sex	Social Security Number
Address (Street, City, County, State, Zip)		
Date of Birth	Relationship	

I certify the individual I have named above as a sponsored dependent:

1. Is an adult over the age of 25.
2. Is dependent on me for support and is listed as a dependent on my most recent tax return. I have attached a copy of the tax form.
3. Is related to me by blood or marriage.
4. Resides permanently in my home.
5. Is not eligible for Medicare.

I understand that falsely certifying eligibility requirements in any respect could result in disciplinary action, that the University may request additional eligibility evidence, that I will be liable for all expenditures for coverage and benefits plus any administrative expenditure and that I must notify the Total Compensation and Wellness Department immediately when a dependent becomes ineligible.

I certify that the information provided is true and correct. I authorize the University to change my benefit enrollments and to adjust my payroll in accordance with the changes I have requested.

I authorize release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature of Employee	Date Signed
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