Overage Dependant Enrollment Form

Employer: _____ **Group / Policy # :** _____

Personal Information

Employee Last Name	Employee First Name	Certificate Number
_____	_____	_____

Dependant Last Name	Dependant First Name	Date of Birth
_____	_____	_____ (mm / dd / yyyy)

Reason for Coverage of Overage Dependant (Check One):

Full Time Student: ☐ Disabled: ☐

If Full Time Student, please provide the following information:

1. Name and Location of School:

_____

_____

2. Approximately how long will he/she be attending school on a full time basis?

_____

_____
Employee Signature

_____
Date

_____
Employer's Authorized Name (Please Print)

_____
Title

_____
Employer's Authorized Signature

_____
Date

NOTE: An Overage Dependant Enrollment Form must be filled out on a year-to-year basis for continuous coverage.