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: ☐ Date of Disability _____

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.