Coatesville Area School District

Dependent Certification Form

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent. *If you are enrolling a full-time student between the ages of 19 and 23, you must provide documentation from the school showing their full-time status each semester (i.e. student schedule, letter from the student's school).*

SECTION A: GENERAL INFORMATION

1. Name of Employee (print – last, first and MI)	2. Employee's Social Security Number
3. Employee's Address (house number, street, city, state and zip code)	
4. Dependent Name (print – last, first and MI)	5. Dependent's Birthdate (MM/DD/YYYY)

6. Dependent's Relationship to Employee	7. Dependent's Marital Status	If dependent is married, provide date of marriage (MM/DD/YYYY)
☐ Son ☐ Daughter ☐ Other	☐ Single ☐ Married	

SECTION B: STUDENT DEPENDENT CERTIFICATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled	2. Type of school (i.e. college, trade, etc.)

3. Student enrolled	4. Will the dependent be graduating within 12 months?
☐ Full-Time ☐ Part-Time ☐ Post-Graduate _____ Number of Credits	☐ Yes ☐ No If "Yes," please provide the expected graduation date: _____ *Failure to provide the expected graduation date may result in delayed processing and/or termination of dependent coverage.*

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.

_____	_____	_____	_____
Signature of Employee	*Phone Number*	*Email Address*	*Date Signed*

SECTION C: DISABLED DEPENDENT CERTIFICATION *(To be completed by Physician)*

Is dependent now incapable of self-support because of a disability? ☐ Yes ☐ No	2. Dependent's age when disability occurred
3. Nature of disability (please provide as much detail as possible)	
4. Prognosis (estimate in months or years)	
5. Name of Primary Care Physician	6. Address of Physician

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.

_____	_____
Signature of Physician	*Date Signed*

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I acknowledge that the dependent listed above is no longer eligible for benefits as a dependent on my vision and dental benefits.

_____	_____	_____
Signature of Employee	*Ineligible Effective Date*	*Date Signed*