



ADULT CHILD CERTIFICATION (Age 19 and Older)

I hereby request medical coverage under the University of Toledo self-insured plan for my adult child shown below. Please complete one form for each child age 19 and older. Please see page 2 of this form for a complete eligibility breakdown.

Employee Name: _____ Rocket ID or SSN: _____

Campus: Main Campus Health Science Campus

ADULT CHILD INFORMATION

Adult Child Name: _____ SSN: _____

Relationship to Employee: Child Stepchild Custodial Child Child of Domestic Partner

Date of Birth: ____/____/____

IRS Dependent: Yes No

Marital Status: Single Married Divorced Separated

Address: _____ City _____ State _____ Zip _____

Full time Student: Yes No Number of Credit Hours: _____

Name of School: _____ Expected Graduation (Month/Year) _____

Is this Adult Child employed? Yes No Full time Part time

Name of employer: _____

Address: _____

Does employer offer health insurance for which Adult child is eligible? Yes No

If Yes, has this Adult Child enrolled in coverage for which they are eligible? Yes No

Name of other insurance carrier: _____

Policy Number: _____ Effective Date _____

Is this Adult Child eligible for Medicaid or Medicare? Yes No

I certify that all information provided on this form is correct to the best of my knowledge and authorize release of any information requested by The University of Toledo (UT) with respect to this Certification. I will provide UT with certification of continuing eligibility annually or when requested. I also understand that my Adult Child's coverage will automatically terminate if response is not received within 60 days from the date of request. I understand that coverage terminates when the Adult Child no longer meets the criteria of Adult Child noted within our Plan eligibility provision. I **agree to notify UT immediately** when the Adult Child no longer meets the Adult Child eligibility provisions. I understand that, upon enrollment of the Adult Child, UT will adjust monthly Plan contributions, if applicable, to reflect the surcharge for that coverage and that the surcharge will be paid by me as an after tax deduction.

Signature of Employee

Date

Human Resources

Mail Stop 205 • 2801 W. Bancroft St. • Toledo, Ohio 43606-3390
419.530.4747 Phone • 419.530.1490 Fax • www.utoledo.edu/depts/hr



Eligibility Breakdown:

- Medical/Rx
 - Age 19 – 26 (end of calendar year they turn age 26)
 - Married and unmarried dependents
 - Not required to be a full-time student
 - Not required to be an IRS dependent
 - Cannot be eligible for other employer sponsored coverage, regardless of cost
 - Cannot be secondary on coverage
 - Age 26 – 28 (end of month they turn age 28)
 - Unmarried
 - Not required to be an IRS dependent
 - Must be State of Ohio resident OR full-time student out-of-state
 - Must be child, step child, or custodial child of employee
 - Cannot be eligible for other employer sponsored coverage, regardless of cost
 - Cannot be secondary on coverage
 - Additional post-tax premium will be charged per adult child
- Health Savings Account/Flexible Spending Account
 - Must be IRS dependent
- Dental
 - Age 19 – 24 (end of calendar year they turn age 24)
 - Unmarried
 - Full-Time Student
 - IRS Dependent
- Vision
 - Age 19 – 24 (end of calendar year they turn age 24)
 - Unmarried
 - Full-Time Student
 - IRS Dependent
- Fee Waiver
 - Age 19 – 24 (end of calendar year they turn age 24)
 - Unmarried
 - Full-Time Student
 - IRS Dependent
- Life Insurance
 - Age 19 – 24 (end of calendar year they turn age 24)
 - Unmarried
 - Full-Time Student
 - IRS Dependent

Human Resources