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.

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 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 30 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 • Email: Benefits@utoledo.edu

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