Qualified Adult Dependant
(Ages 19 – Up to Age 26)

Employee Information:

Last Name:	First Name, Middle Initial:	Employee ID:

Department:	Effective Date of Dependant Enrollment:

Qualified Dependant Information:

Last Name:	First Name, Middle Initial:	Social Security Number:
Relationship to Employee:	**Date of Birth:**	**Gender:** ☐ Male ☐ Female

Address:	City:	State:	Zip Code:

Qualified Adult Child's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Is this Qualified Dependant Employed? ☐ Yes ☐ No	Employment Status: ☐ Part-Time ☐ Full-Time	Does the employer offer health insurance for which the Dependant is eligible? ☐ Yes ☐ No	Name of Employer:
Employer Address:	**City:**	**State:**	**Zip Code:**

Complete the section below only if the Qualified Dependant is married:

Is coverage available through the Dependant's Spouse's Employer? ☐ Yes ☐ No	If yes, Name of Qualified Dependant's Spouse's Employer:		
Address of Dependant's Spouse's Employer:	**City:**	**State:**	**Zip Code:**

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 Victor Treatment Center (VTC)/Victor Community Support Services (VCSS) or Blue Shield of California with respect to this Certification. I will provide VTC/VCSS and/or Blue Shield of California with certification of continuing eligibility annually or when requested. I also understand that my Qualified Dependant coverage will automatically terminate if response is not received within 60 days from the date of request.

I understand that coverage terminates when the Qualified Dependant no longer meets the criteria of Qualified Dependant noted with our Plan eligibility provision and no later than the end of the month in which Qualified Dependant reaches age 26. I agree to notify VTC/VCSS immediately when the Qualified Dependant no longer meets the Qualified Dependant eligibility provisions.

Employee Signature **Date** **Adult Child Signature** **Date**