Application for Enrollment to Continue/Add Coverage for Dependents Over Age 26

This form is to be used to add/continue enrollment for your dependent pursuant to 2008 SB 2534, FL Stat. Ann, § 627.656. Please contact your group administrator for specific eligibility requirements for your dependent under your employer group coverage. Please complete all sections unless otherwise directed.

A. Group & Employee Information

Group Name	Group Number
Employee Name	Employee SSN

B. Continuation Information (*Only complete this section if your over-age-26 dependent is not presently covered by Capital Health Plan.)*

Continuation of Coverage pursuant to 2008 SB 2534, FL Stat. Ann § 627.656

Coverage Effective Date: _____/_____/_____

Coverage is being effected:

☐ During an Open Enrollment ☐ Within 30 days of a Qualifying Event *

☐ Within 30 days of Attaining Limiting Age

*Please specify the qualifying event: _____

Billing:

Please note that Capital Health Plan will bill the employer group directly for coverage for this dependent.

C. Over-Age-26 Dependent Information

Name (Last, First, MI)	Sex ☐ M ☐ F	Birthdate (MM/DD/YYYY) / /	Social Security Number - -
Primary Care Physician		Current Patient ☐ Yes ☐ No	

Previous Coverage: ☐ Yes ☐ No

If yes, please provide the following information AND submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

Effective Date of Prior Coverage: ____/____/____ Termination Date of Prior Coverage: ____/____/____

Name of Prior Carrier: _____ Prior Plan Number: _____

D. Eligibility Information

Please check all that apply to the person identified in Part C above:

☐ This person is not eligible for Medicare or enolled in any other group or individual health plan

☐ This person is unmarried

☐ This person does not have any children or other dependent(s)

☐ This person is a Full-Time/Part-Time Student

☐ This person is a resident of Florida

Please note that you must provide a copy of your dependent's valid FL Driver License/ID Card or a letter from the Registrar's Office of your dependent's school to prove eligibility.

By signing below, you acknowledge that the statements on this form are true and complete and that you understand and agree that any misstatements may result in denial of benefits and/or termination of coverage/membership. You also agree and understand that your employer may require that you pay all or part of the additional premium required to cover the over-age-26 dependent that you have requested to be enrolled pursuant to 2008 SB 2534, FL Stat. Ann § 627.6562. You also understand that, based on the information provided above, you may be required to provide additional information to resolve any questions about eligibility for coverage.

Employee Signature: _____ **Date:** _____

Group Administrator Signature: _____ **Date:** _____

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