



Group: PM085516

CEBT Certification of Dependent Status

*This form MUST be completed and signed by the enrollee.
All boxes MUST be checked before you sign.*

Dependent Child Information

Dependent Name:

Date of Birth

Member ID#:

_____ / ____ / _____

Dependent Eligibility Information

1. Yes No Does this dependent meet all of the dependent eligibility requirements listed below?

To be eligible for benefits, the dependent child, if over age 19, must:

Be unmarried;

Be less than 25 years of age; and

Meet one of the following criteria:

Financially dependent on enrollee or enrollee's spouse **OR**

Reside at the same legal residence as the enrollee or the enrollee's spouse.

Please be sure to notify CEBT immediately when the dependent fails to meet any of the eligibility requirements shown above. A completed change form is required to disenroll your dependent.

2. I certify all of the information stated above is true and correct in all respects.

3. I understand and agree that my health plan has the right to terminate coverage and deny benefits if any of the information on the Enrollment Application or this Certification of Dependent Status or as otherwise provided by me to the plan is materially false, inaccurate, or misleading.

Enrollee's Name (please print):

Enrollee's Employer Group:

Enrollee's Signature:

Date:

Please return the completed form to: Fax (608) 783-8621

Fax to: (608) 783-8621

Or Mail to: UMR
2700 Midwest Drive
Onalaska, WI 54650