

Enrollment and Employment Certification Form for Adult Children

COMPLETE THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

To enroll/reenroll your biological or adopted children up to age 26 in the MEBA Medical & Benefits Plan (“MEBA Medical Plan”), please complete and return. If you are re-enrolling your child, all necessary documentation should already be on file with the Plan Office. If you are not sure, contact the Membership Services Department at the above telephone number.

Participant Information

Member Name:	ID or SSN#
Mailing Address:	
City, State & Zip Code	

Adult Child Dependant Eligibility (age 19-25)

In order for an adult child to be eligible for dependant coverage under the MEBA Medical Plan, he/she must meet all of the following requirements:

- The individual is your child by birth or adoption.
- The adult child is not eligible for health benefits through his or her employer or his or her spouse’s employer (employment-based coverage).
- The child is under the age of 26.

Definition of Employment-Based Coverage

Employment based coverage is health coverage that an adult child is eligible for due to the employment of the child or the employment of the child’s spouse, regardless of whether the child enrolls in such coverage. (The adult child’s spouse is not eligible for coverage under the MEBA Medical Plan).

Dependant Information

List all children to be enrolled/reenrolled in the MEBA Medical Plan. Please complete all sections listed below. For adult children, you must provide the name of his or her employer and his or her spouse’s employer (if applicable). Note that the MEBA Medical Plan may contact the adult child’s employer and his or her spouse’s employer concerning the availability of employment-based coverage.

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	DEPENDANT SOCIAL SECURITY NUMBER	RELATIONSHIP TO MEMBER	ELIGIBLE FOR EMPLOYMENT- BASED COVERAGE	PREVIOUSLY ENROLLED IN THE MEBA MEDICAL PLAN
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name (if applicable):	Employer Address:			Employer Phone:	
Child’s Spouse’s Employer Name (if applicable):	Child’s Spouse’s Employer Address:			Child’s Spouse’s Employer Phone:	

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	DEPENDANT SOCIAL SECURITY NUMBER	RELATIONSHIP TO MEMBER	ELIGIBLE FOR EMPLOYMENT- BASED COVERAGE	PREVIOUSLY ENROLLED IN THE MEBA MEDICAL PLAN
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name (if applicable):		Employer Address:		Employer Phone:	
Child's Spouse's Employer Name (if applicable):		Child's Spouse's Employer Address:		Child's Spouse's Employer Phone:	

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	DEPENDANT SOCIAL SECURITY NUMBER	RELATIONSHIP TO MEMBER	ELIGIBLE FOR EMPLOYMENT- BASED COVERAGE	PREVIOUSLY ENROLLED IN THE MEBA MEDICAL PLAN
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name (if applicable):		Employer Address:		Employer Phone:	
Child's Spouse's Employer Name (if applicable):		Child's Spouse's Employer Address:		Child's Spouse's Employer Phone:	

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	DEPENDANT SOCIAL SECURITY NUMBER	RELATIONSHIP TO MEMBER	ELIGIBLE FOR EMPLOYMENT- BASED COVERAGE	PREVIOUSLY ENROLLED IN THE MEBA MEDICAL PLAN
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name (if applicable):		Employer Address:		Employer Phone:	
Child's Spouse's Employer Name (if applicable):		Child's Spouse's Employer Address:		Child's Spouse's Employer Phone:	

Authorization and Signature

The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependants listed on this form fully meet the listed definition of eligibility. I understand that if I do not provide complete and accurate information, my child's eligibility will be terminated retroactively and I and my child will be liable for any claims that would not have been paid.

Signature of Participant

Date Signed