Human Capital Management Capital Management
Employee Benefits Department

STATE EMPLOYEE APPLICATION FOR COVERAGE FOR OTHER DEPENDENT CHILDREN

2401 N. Lincoln Blvd., Oklahoma City, OK 73105 – Phone: 405-522-5528 or 800-219-8115

You must complete this form to request coverage for an unmarried child, other than your own daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption, who lives with you in a parent-child relationship, and for whom you are financially responsible. **Documentation of guardianship or your most recent income tax return listing the child as your dependent should be provided with this application.** All questions must be answered fully.

☐ New hire ☐ Midyear ☐ Option Period

Agency name______________________________ Agency number location code_____________

Employee name____________________________________ SSN or member ID_____________

Employee address_____________________________ City____________ State____ ZIP_______

Child full name_______________________________________ Date of birth_________________

Child SSN______________________________ ☐ Male ☐ Female

1. What is the child's relationship to you? ____
2. Date (month/day/year) the child entered your home ______________________________
3. Do you intend to claim the child on your future tax return(s)? _______________________

   If no, explain:____

Indicate the coverages below in which you wish to enroll this dependent. When one eligible dependent is covered, all eligible dependents must be covered, and this dependent will be added to the same level of coverage.

☐ Health ☐ Vision ☐ Dental

Dependent Life ☐ Premier ☐ Standard ☐ Low

Requested effective date __________________

I certify all information provided above is true and correct, and failure to provide correct information may result in denial or cancellation of dependent coverage and consequent denial or recoupment of claims payments. I understand giving false information to obtain insurance is a criminal act defined as fraud under Oklahoma statutes and is punishable by fine and/or imprisonment.

Employee signature ____Date __________________

FOR EBD USE ONLY

Approved Effective date _____________ Denied _____________

___________________________________ ___________________________________
Authorization signature Date

Application for Coverage for Other Dependent Children

The Application for Coverage for Other Dependent Children is required to request health, dental, vision and/or life coverage on a child when you have not been granted custody, adoption or guardianship by a court. **This application is not required if any of these conditions are met or if the dependent is your natural child or stepchild.** You should then follow the Employee Benefits Department dependent enrollment procedures.

You can request dependent coverage on a child in your home when a parent-child relationship exists between you and the child. The request must be made within 30 days of the child entering your home. If coverage is not requested within 30 days, you cannot add coverage until the next annual Option Period and benefits limitations may apply.

The Application for Coverage for Other Dependent Children must be submitted to EBD and approved before any coverage is allowed for a child when no court order exists and when the child is not listed on your most recent income tax return. Coverage, if approved, shall begin on the first day of the month following approval and will never apply retroactively except in the case of a newborn, which shall be added the first of the month of birth.

You must have Basic Life coverage in order to request Dependent Life. All other applicable eligibility requirements must be satisfied and all necessary premiums must be paid.

Note: It is your responsibility to notify your agency's benefits coordinator when your child becomes ineligible.

Current employees should return this form to their agency's benefits coordinator.