# DEPENDENT CERTIFICATION FORM

## 1- Subscriber and Dependent Information

| SUBSCRIBER'S LAST NAME | SUBSCRIBER'S FIRST NAME | INITIAL | IDENTIFICATION NUMBER |
|---|---|---|---|
| | | | |

| DEPENDENT'S LAST NAME | DEPENDENT'S FIRST NAME | INITIAL | DEPENDENT'S DATE OF BIRTH |
|---|---|---|---|
| | | | ____/____/____ mm dd yyyy |

## 2- Does the dependent have any other insurance coverage?

☐ NO, please continue to question #3

☐ YES, please answer the following:

a) Type of Coverage: ☐ Medical and/or ☐ Dental

b) Other Insurance Carrier ID #: _____

c) Effective Date of Other Insurance Coverage: _____/_____/_____
mm dd yyyy

d) Other Insurance Company:

☐ CDPHP

☐ Other Carrier, indicate plan name: _____

☐ Other Carrier, indicate plan name: _____

## 3- Is the dependent married?

☐ NO, continue to question #4

☐ YES, please indicate marriage date: _____/_____/_____
mm dd yyyy

## 4- Is the dependent currently enrolled as a full-time student at an accredited school/college?

☐ YES, please answer the following:

a) Name of Accredited School/College: _____

b) Expected Graduation Date: _____/_____/_____
mm dd yyyy

c) Will the dependent continue on to further education after graduation? ☐ Yes ☐ No ☐ Unknown

☐ NO, please answer the following:

a) Date Student Status Ended: _____/_____/_____
mm dd yyyy

b) Reason Student Status Ended:

☐ Graduated

☐ Voluntary Disenrollment

☐ Medically Necessary Leave of Absence

☐ Your dependent may be entitled to continue coverage for up to six months for a medically necessary leave of absence that: starts when the child is suffering from a serious illness or injury, is certified by a physician as medically necessary; and causes the child to lose student status for coverage under your plan. Along with this form, a 'Continued Student Coverage Request For Medically Necessary Leave of Absence' form, completed by you or the member and the dependent's physician, must be submitted. The form can be obtained from our Web site at www.cdphp.com or by contacting our Customer Care department at the phone number listed on your member card.

☐ Other: _____

## 5- Signature and Date

I certify that the information submitted is accurate to the best of my knowledge.

**SIGNATURE:** _____ **DATE:** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the release.

Please ensure that all sections are complete, signed, and dated prior to returning. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of this request.

**Please return completed form to: P.O. Box 21494**
**Eagan, MN 55121**