

Adult Dependent Coordination of Benefits Form



State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED

Check Carrier: Highmark BCBSD Aetna

EMPLOYEE FULL NAME - Last, First, Middle Initial		YOUR HOME PHONE - Include area code	
EMPLOYEE SOCIAL SECURITY NUMBER		Check one: This is the first form for my adult dependent <input type="checkbox"/> This is an updated form for my adult dependent <input type="checkbox"/>	
ADULT DEPENDENT'S FULL NAME - Last, First, Middle Initial	ADULT DEPENDENT'S SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male <input type="checkbox"/> Female	DEPENDENT'S BIRTH DATE / /

EMPLOYER INFORMATION

MY ADULT DEPENDENT IS: <input type="checkbox"/> Full-time Student <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Not Employed		
NAME AND ADDRESS OF EMPLOYER		EMPLOYER PHONE NUMBER Include Area Code
Does this employer offer health care insurance to employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your adult dependent enrolled in health care insurance through this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your adult dependent be required to pay?*
	Is this a High Deductible Plan with a Health Savings Account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the name of your adult dependent's health care insurance carrier'?	What is the plan policy number? Effective Date:	Annual plan renewal date for this employer: Month: Day:
Does this employer's medical plan cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Your additional comments:	
If you are completing this form due to your adult dependent's loss of coverage please indicate the termination date of that coverage. Date:		

AUTHORIZATION

I understand that the following policy applies to adult dependents age 21 to 26 who are eligible for health care coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If adult dependents over age 21 take advantage of their own employer's health care coverage, these plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If adult dependents over age 21 do not take advantage of their own employer's health care coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must also be completed every year during Open Enrollment or any time my adult dependent's employment or coverage situation changes in order to cover my adult dependent under the State of Delaware Group Health Insurance plan. The form is used to determine eligibility to receive primary State of Delaware health benefits. Generally, the following adult dependents over age 21 are not required to enroll in their employers' plans:

- Adult dependents who are full-time students under age 24, or
- Adult dependents who are not working full time, or
- Adult dependents whose employer does not offer health care coverage, or
- Adult dependents whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

If any of this information changes, I must complete a new form within 30 days and submit to my agency benefits representative.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your adult dependent's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your adult dependent. Any claims paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

Please return completed form to your organization's Human Resources or Benefits Representative.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT	
Member's Signature:	Date: / /