

Baldwin-Wallace College
Application to Cover Older Adult Child Age 26-28

Employee Last Name: _____ **First Name:** _____

Employee Department: _____ **Employee SSN:** _____

Child's Last Name: _____ **First Name:** _____

Child's SSN: _____ **Child's Date of Birth:** ____/____/____

Procedures: This application form is to be completed by the employee and forwarded to Human Resources (HR). HR will review the application to determine if the child is eligible to be covered and will notify the employee if the child is eligible or not. If the child is determined to be eligible, an enrollment form and information regarding premiums will be sent. A separate form for each Older Adult Child is required if an employee seeks to cover more than one child. A new application form needs to be completed every year at open enrollment or one year after child initially applies for coverage.

1. Relationship (circle one): **Biological child** **Adopted child** **Stepchild** **Legal guardianship**
Children include biological children, adopted children, stepchildren, and children for whom you have legal guardianship as long as you are able to provide the necessary documentation. The coverage under the Baldwin-Wallace College plan will be provided for eligible children effective January 1, 2012.

2. I am requesting to enroll my child in my: Medical Mutual _____ Kaiser Permanente _____

3. Is your child married? Yes _____ No _____

4. Does your child live in Ohio? Yes _____ No _____

5. If yes, please provide child's address _____

6. Is child full-time college student? Yes _____ No _____ **Name of College:** _____

7. Is your child currently employed? Yes _____ No _____

If yes, current employer's name and address: _____

8. Is your child eligible for his or her own employer-sponsored health coverage? Yes _____ No _____

9. Is your child currently eligible for Medicare or Medicaid? Yes _____ No _____

I understand that enrollment for benefits to which my dependents, my child or I am not entitled is considered fraud. If I willfully misrepresent the eligibility of myself or my children or dependents, fail to take the necessary action to remove ineligible children or dependents, or in any way obtain benefits to which my children or dependents are not entitled, my benefits will be canceled. I will be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from Baldwin-Wallace College. I further understand that if this dependent ceases to remain an eligible dependent, I am required to notify Human Resources in writing within 31 days of the termination of the dependency, and the coverage for the dependent will cease at the end of the period for which premiums or administrative fees have been paid. Baldwin-Wallace College reserves the right to request additional documentation at any time to substantiate eligibility. **I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, and belief.**

Signature of Employee

Date