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North America
Administrators

ADULT DEPENDENT CHILD INFORMATION

In compliance with the new Patient Protection and Affordable Care Act (PPACA), coverage for employees' adult children up to age 26 is now offered under the Company's Group Health Plan. According to IRS Notice 2010-38, a "child" is an individual who meets any of the below definitions. **NOTE: You must complete and sign this form if you are enrolling an adult child.**

Company Name: _____

Employee's Name: _____ SSN: _____

Adult Child Information: (If additional adult children are being enrolled, please complete a separate form for each individual.):

Name: _____ SSN: _____

The above-named individual qualifies as my child based on the following category:

- Natural or adopted son or daughter
- Stepson or stepdaughter
- A child placed with the employee for purposes of adoption
- A foster child placed with the employee by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction.

Is the above-listed child employed? YES NO

If YES, Name of Employer: _____ Phone: (____) _____

Is the child covered under his/her employer's medical plan? YES NO

If NO, please check any that apply:

- My child has insurance available through his/her employer, but has not elected coverage.
- My child is self-employed and does not currently have access to group health insurance.
- My child works part-time and insurance is not offered.
- Insurance is not available at my child's place of employment.
- My child is in a waiting period for insurance that will become effective on _____.

Is the above-listed child married? YES NO

If YES, is the child eligible for coverage under the spouse's employer's medical plan? YES NO

OTHER INSURANCE INFORMATION, IF APPLICABLE:

Not counting any coverage indicated above through the child's or his/her spouse's employer, is the child covered under any other group health plan? YES NO

If YES, please provide the following information:

Name of Other Insurance Company: _____

Address of Other Insurance Company: _____

Group and/or Policy Number: _____

I hereby declare that the above information is true and accurate to the best of my knowledge. I understand that if I intentionally misrepresent the nature of my relationship to the above-named individual or the stated facts regarding eligibility for coverage under his/her (or the spouse's) employer's group health plan, he or she may be disqualified for coverage under my employer's group health plan. I hereby authorize all providers rendering care and treatment to furnish North America Administrators with full information regarding medical treatment (including copies of their records). A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature: _____ Date: _____