Dependent Verification Form

KAISER PERMANENTE®

• This form enables the subscriber on a Kaiser Permanente employer group health plan account to extend coverage for a son or daughter beyond the age limit normally set by the subscriber's group plan, under certain conditions governed by Colorado regulation.

• You may continue your child's coverage under your employer group health plan if he or she
1) is under age 25 and unmarried, **and**
2) financially dependent on you, the subscriber, or has the same legal residence as you.

• To extend your child's coverage under your group health plan under this provision, please complete and sign this form certifying that your child meets **both** legal requirements.
In addition, please notify your employer's benefit office of this request, as an additional premium may be required to extend such coverage.

• Please note that when your child reaches age 25, gets married, or is no longer financially dependent on you and/or no longer shares your legal address, he or she no longer qualifies for this extended coverage.
You must notify Kaiser Permanente within 31 days of any such change in circumstances. We can help your son or daughter find suitable coverage at that time.

Dependent Detail

Full name _____

Address _____

City_____ State_____ Zipcode _____

Dependent's birth date _____ Member ID# _____

Subscriber Detail

Full name _____ Member ID # _____

Address _____

City _____ State _____ Zipcode _____

Employer Detail

Employer name _____ Group number _____

Effective Date of Coverage _____

Subscriber Signature

My signature certifies that my child, listed above, meets the eligibility requirements described for continuing dependent coverage as of the date of my signature.

Signature _____ Date _____

Please mail the completed and signed form to:

Kaiser Permanente
P.O. Box 921010
Ft. Worth, TX 76121-1010