

THE SCHOOL DISTRICT OF PALM BEACH COUNTY
APPLICATION FOR MEDICAL INSURANCE FOR OVER AGED ADULT CHILDREN
(Unmarried 26 – 30 years of age)

A separate application must be completed for each adult child applying for coverage. Coverage will become effective on the 1st of the month following receipt of the application and required documents as listed below.

The adult child is not eligible to be covered under this plan unless the adult child was continuously covered and can provide a Certificate of Creditable coverage demonstrating that there has not been a gap in coverage of more than 63 days. An original government-issued certificate must also be submitted at the time of application.

I understand and confirm that my child was continuously covered and also meets the other criteria outlined below. Additionally, I understand that coverage will be in the same plan* in which I am enrolled and a separate individual premium is due from my payroll deduction for this coverage.

2012 Medical Monthly Premiums per Over-age Adult Dependent:

Plan Types* Low HMO \$367.02 High HMO \$428.44 PPO \$860.64

The above coverage is being requested for the following child:

Child's Name	- - - - - Date of Birth	- - - - - Social Security No.	
Child's Address	City	State	Zip Code

I attest that my child (**REQUIRED check all that are applicable**):

- Is unmarried and has no dependents of his or her own;
- Does not otherwise have available other major medical health insurance
- Lives in Florida or is a student in another state
- Has continuously been insured (attach a Certificate of Creditable coverage)

I understand the premiums are deducted on a post-tax basis. The above premium amount will be applied for coverage of the one over-age adult child. I authorize the School District to deduct the required premiums from my paycheck.

I further understand that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a third-degree felony. FLa. Statute Ch 817.234 (1) (b) (2000).

Employee name (print)	Employee ID No.	Employee Signature
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REQUIRED: Original Birth Certificate and Certificate of Creditable Coverage

Return Completed Form to:
Risk and Benefits Management
3370 Forest Hill Blvd, A-103
West Palm Beach, FL 33406-5870

Risk and Benefits Management Use Only		
Effective:	/01/2012	Plan Type:
Received:		Monthly \$
Entry Date:		Carrier Notified: / /
Scanned:		Term Effective:
Comments:		Carrier Notified: / /