UNITED CONCORDIA

Please send to: Human Resources
Muhlenberg College
fax(484)664-3190
megganmusselman@muhlenberg.edu

The fields in this PDF form can be filled in electronically using Adobe Acrobat Reader software (version 4 or higher). Once completed, you may print out this form to mail or fax to United Concordia. You can also use the "Save As Copy" function (under the File menu) to save the form as completed for future reference.

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent.

SECTION A: GENERAL INFORMATION *(To be completed by Employee)*

1. Name of Employee (print - last, first & middle initial)

2. Contract ID Number (Such as SSN)
__ __ __ __ __ __ __ __ __

3. Employee's Address (number, street, city, state & zip code)
__ __

4. Dependent Name (print - last, first & middle initial)

5. Dependent's Birthdate (mm/dd/year)

6. Dependent's Relationship to Employee
☐ Son ☐ Daughter ☐ Other

7. Dependent's Marital Status
☐ Single ☐ Married

If dependent is married, provide date of marriage (mm/dd/year)

8. Is dependent currently covered under a medical plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

9. Is dependent currently covered under another dental plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

SECTION B: STUDENT DEPENDENT CERTIFICATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled

2. Type of school (i.e., college, trade etc.)

3. Student enrolled
☐ Full-Time ☐ Part-Time ☐ Post-Graduate _____ Number of Credits

4. Expected graduation or disenrollment date (mm/year)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee | Phone Number | Email Address | Date Signed

SECTION C: DISABLED DEPENDENT CERTIFICATION *(To be completed by Physician)*

1. Is dependent now incapable of self-support because of a disability?
☐ Yes ☐ No

2. Dependent's age when disability occurred

3. Nature of disability (please provide as much detail as possible)

4. Prognosis (estimate in months or years)

5. Name of Primary Care Physician (print or type)

6. Address of Physician (print or type)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Physician | Date Signed

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.

Signature of Employee | Ineligible Effective Date | Date Signed