



DECLARATION OF QUALIFIED DEPENDENT STATUS

MEMBER MUST COMPLETE AND AGREE TO THE FOLLOWING FOR ALL ADULT CHILDREN AGE 19-26.

Member's Name: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Address: _____

I hereby certify that my child(ren) listed on the back of this form is:

- 1. Between the ages of 19 and up to, but not including, age 26; and**
- 2. Does not have access to his/her own employer's group health insurance, regardless of cost.**

- I understand that TeamstersCare will rely upon the information contained in this declaration in making its determination regarding my dependent's eligibility to receive benefits from TeamstersCare.
- I understand that I must notify TeamstersCare immediately if my dependent becomes eligible to participate in a group health plan through his/her employer or his/her spouse's employer. At that time, TeamstersCare will terminate my child's coverage.
- I understand that TeamstersCare reserves the right to periodically conduct an audit to verify that my child does not have access to his/her own employer's group health insurance, and I agree to cooperate fully in any such audit.
- If TeamstersCare provides benefits to which my dependent is not entitled, I will assume responsibility for any expenses paid out by TeamstersCare for the ineligible period(s). If I fail to do so, my benefits and the benefits of my qualified dependents may be suspended.

Member's Signature

Date

Important:

If a dependent permanently lives outside the New England area, the entire family may enroll in the Out of Area plan, Blue Care Elect Preferred. HMO's only cover expenses for services in the New England Area, except in cases of emergency.

In this case, please contact TeamstersCare Member Services at 617-241-9220 ext 2 to change your family's enrollment to the Blue Care Elect Preferred Plan.

Enter Adult Children Information on the Other Side

Please list all Qualified Adult Children Age 19 - 26

(If a dependent is a new enrollment, a copy of their birth certificate or legal documentation of custody is required.)

Dependent Name: _____ DOB: _____

SS# : _____ Sex : F M

Permanent Address: _____
Street City State Zip Code

Primary Care Physician (PCP) Information:

PCP Name: _____ PCP Location: _____ PCP #: _____

Dependent Name: _____ DOB: _____

SS#: _____ Sex: F M

Permanent Address: _____
Street City State Zip Code

Primary Care Physician (PCP) Information:

PCP Name: _____ PCP location: _____ PCP #: _____

Dependent Name: _____ DOB: _____

SS#: _____ Sex: F M

Permanent Address: _____
Street City State Zip Code

Primary Care Physician (PCP) Information:

PCP Name: _____ PCP Location: _____ PCP #: _____

Dependent Name: _____ DOB: _____

SS# _____ Sex: F M

Permanent Address: _____
Street City State Zip Code

Primary Care Physician (PCP) Information:

PCP Name: _____ PCP Location: _____ PCP #: _____