CMS

ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

LOCAL GOVERNMENT HEALTH PLAN

DEPENDENT COVERAGE CERTIFICATION STATEMENT

EMPLOYEE NAME: **MBR. SSN:** - -

DEPENDENT NAME: **DEP. SSN:** - -

CERTIFICATION DATE:

I certify that the above dependent meets ALL of the qualifications for continued coverage in the dependent category checked below. I have attached the required documentation as stated on the back of this Statement.

Dependent Category *(Check One)*	**Qualification**
____ Student	Dependent age 19 and up to, but not including, age 23. Enrolled as a full time student in an accredited school, eligible to be claimed for income tax purposes, and is financially dependent upon me.
____ Handicapped	Age 19 or older and continuously disabled from a cause originating prior to age 19, eligible to be claimed for income tax purposes, and is financially dependent upon me.

BE SURE TO INCLUDE THE REQUIRED DOCUMENTATION AS STATE IN THE ATTACHED LETTER FOR THE CATEGORY SELECTED ABOVE

____ **Terminate Dependent:** My dependent no longer meets the eligibility criteria. By checking the "Terminate Dependent" line and signing below, I am authorizing the termination of my dependent's coverage.

I understand that it is my responsibility to notify my agency Insurance Representative when and if the above Person ceases to meet the qualification as stated above. I acknowledge and understand that failure to notify the State of changes in my dependent's status will result in termination of coverage retroactive to the last eligible date, Recovery of all claim payments and possible forfeiture of premiums paid.

(Member's Signature) (Date) (Insurance Rep's Signature) (Date)

RETURN THIS FORM TO YOUR INSURANCE REPRESENTATIVE