weatrust.com

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Adult Child Eligibility Form–Dental Coverage

Your adult child's dental insurance will end if he/she does not meet the eligibility criteria for an adult child over age 19. If you believe he/she is eligible for continued coverage, you must complete this form to request coverage for your child who is 19 years or older.

Section A: Must be completed

Subscriber Name: _____ Member No.: _____

Child's Name: _____ Date of Birth: _____

1. My adult child is single:
   ☐ Yes ☐ No If No, Date of Marriage: _____ (go to Section C)
2. My adult child is in the military:
   ☐ No ☐ Yes If Yes, Date Active Duty: _____ (go to Section C)
3. My adult child's employment situation (check one):
   ☐ My adult child is not employed (go to Section B).
   ☐ My adult child is employed but is not eligible for dental insurance through his/her employer (go to Section B).
   ☐ My adult child is employed and is eligible for dental insurance through his/her employer (complete #4).
4. Compare your adult child's premium contribution for dental insurance through his/her employer to the additional premium amount you are required to pay to insure your child on your policy. Check the box under a. or b. below that describes your situation.
   a. I need family coverage regardless of whether I choose to cover this adult child because I have other eligible dependents on my policy, so I will not be required to pay any additional premium amount to insure my adult child. My adult child's premium contribution for dental insurance through his/her employer is:
      ☐ $0 (go to Section C). ☐ More than $0 (go to Section B).

   OR

   b. I only need family coverage if I choose to cover this adult child under my policy because I have no other eligible dependents. To insure this child, my additional premium is the difference between the amount that I pay now toward the premium for my single coverage and the amount that I will have to pay toward the premium for family coverage.

      My adult child's monthly premium contribution for dental insurance through his/her employer is:
      ☐ Equal to or less than the additional monthly premium that I will have to pay for family coverage (go to Section C).
      ☐ More than the additional monthly premium that I will have to pay for family coverage (go to Section B).

Section B: Adult Child is Eligible

Based on my responses in Section A, my adult child is eligible for coverage. (Disregard Section C)

☐ I request dental insurance coverage for my adult child.

To the best of my knowledge, all statements and answers above are complete and true. All information is furnished under penalty of Wis. Stats. § 943.395. I understand that fraud or material misrepresentation of the adult child's eligibility for coverage will result in termination of that coverage retroactive to the date eligibility was lost, and I will be responsible for the cost of claims paid during the period when coverage should not have been in effect, together with all costs and legal fees incurred by the Trust in recovering those claims payments.

I understand that if there is any change in my adult child's eligibility after this form is completed, I must notify the Trust immediately. I further understand that, if I fail to do so, I will be responsible for the cost of any claims paid after my child ceased being eligible for coverage as my dependent, together with all costs and legal fees incurred by the Trust in recovering those claims payments.

☐ I do not request dental insurance coverage for my adult child. I understand that by not electing coverage for my eligible child, I may not later elect coverage unless my child qualifies for coverage under the late enrollment provisions for the Trust policies. I also understand that because I am choosing not to continue dental insurance coverage for my eligible child, it is a voluntary cancellation and my child is not eligible for COBRA continuation coverage.

X _____ _____
Subscriber's Signature Date

(*Keep a copy of your completed form for your records.*)

Section C: Adult Child is Not Eligible

Based on my responses in Section A, my adult child is **not** eligible for coverage. Please promptly return this form to the WEA Trust for further information on COBRA continuation options that may be available for your dependent.