



CERTIFICATION OF DEPENDENCY FORM

AP-FM07-012

PLEASE NOTE: Claims in process for the dependent in question may be pended until eligibility is updated and approved. Therefore, it is very important to complete this form in its entirety. (In the event dependent eligibility cannot be determined based on the answers submitted on this form, additional information may be requested to continue the determination process.)

TRH Subscriber Name: _____ HEALTH ID # _____

Address: _____ DENTAL ID# _____

City, State, Zip: _____ DAYTIME PHONE: () _____

THE FOLLOWING QUESTIONS MUST BE ANSWERED BY THE SUBSCRIBER

- 1. Dependent Name: _____ Date of Birth: ___/___/___
2. Relationship: () Biological Child () Adopted Child () Step-Child () Other _____
3. Is or has the dependent ever been married? () YES () NO If "YES," give date of marriage _____
4. Is the dependent a full time student? () YES If "YES," Provide Name of School/College: _____ () NO If "NO," Please provide date dependent was no longer a full-time student: _____
5. Is the dependent residing full time in your home? () YES () NO If "NO," and the dependent is not a full-time student, please provide the date dependent moved out: _____
6. Is there a divorce decree establishing custody and/or a responsible party for providing medical and/or dental coverage for the dependent? () YES () NO If "YES," and you have not provided a copy of this information, please submit a complete copy of the Final Decree of Divorce and Permanent Parenting Plan or other legal documents establishing custody and/or responsible party for providing medical and/or dental coverage.
7a. Is the dependent currently employed? () YES () NO If "Yes," date employed: ___/___/___ What is the total current average weekly salary? \$ _____
7b. If the dependent is not currently employed, has the dependent ever been employed? () YES () NO If "Yes," date(s) employed: _____; total average weekly salary amount: \$ _____
7c. Does the dependent receive other income in addition to the above employment information listed in Question No. 7a or 7b? (Such as working on a farm with you or in your business?) () YES () NO If "YES," what is the total current average weekly salary for this other income? \$ _____
8. Do you provide 51% or more of this dependent's support? () YES () NO If "Yes," additional detail may be requested, if needed to qualify 51% support.
9. Is the dependent incapable of self-support due to physical or mental incapacity? () YES () NO If "YES," a separate physician's certification form is required and will be sent to you.
10. Has the dependent been required to take a medical leave of absence or make other enrollment changes because of a serious illness or injury while attending a post secondary educational institution, which would be applicable to "Michelle's Law," as defined below. () YES () NO If "YES," a "Dependent Student Medical-leave Physician Certification Form" will be sent to you. Please have the dependent's attending physician complete the form and return to TRH.

X _____ SUBSCRIBER'S SIGNATURE

_____/_____/_____ DATE

"A new federal law, Michelle's Law, became effective January 1, 2010. This federal law allows dependent college students to continue coverage on their parent's plan if they are required to take a medical leave of absence, or make other enrollment changes, because of a serious illness or injury while attending a post-secondary educational institution. The dependent must have been enrolled in the TRH health plan immediately before the first day of the leave. A physician must certify, in writing, that the leave of absence, or other enrollment change, is medically necessary. If the leave of absence or enrollment change would cause the dependent to lose eligibility on their parent's coverage, the dependent may continue coverage for up to one year from the first day of the leave of absence, or until the date on which the coverage would otherwise end, whichever comes first. If the dependent child turns age 24 during the approved medical leave of absence, the dependent's coverage will end on the dependent's 24th birthday in accordance with the EOC."

HOME OFFICE USE ONLY [] Health [] Dental Eligible: ___ Yes ___ No Update/load eligibility: _____
If ineligible, date of ineligibility: ___/___/___ Reason for ineligibility: _____ Member Notified: _____
Other: _____ County Office Name: _____ D.E. determined by: _____