



SELF FUNDING ADMINISTRATORS CORPORATION

339 BUSCHS FRONTAGE ROAD

POST OFFICE BOX 6596

ANNAPOLIS, MARYLAND 21401

DEPENDENT ELIGIBILITY FORM

Employer Name: _____

Employee Name: _____

Insured's Number: _____

Name of Dependent: _____

Please extend coverage under the above policyholder's group medical plan because my dependent is:

1. ___ A full-time student in an accredited school, college or university (enrolled for at least 12 credit hours).

Name of School: _____

Semester/Year: _____

Credit Hours: _____

Expected Graduation Date: _____

2. ___ Totally and permanently disabled. (Please attach verification of disability from your physician to be reviewed for continuing eligibility).

3. ___ My dependent is not a full time student or is no longer an eligible dependent under the plan. Please provide the date in which your dependent has lost his/her full-time student status. (Last Day of School/Graduation Date) ____/____/____

IMPORTANT: You must notify your Human Resources Department within 60 days of the date your dependent is no longer eligible in order to be eligible for continuation of coverage under COBRA.

I certify that the above information is correct and any misrepresentation may result in the termination of benefits. I agree to notify the Human Resources Department and Self Funding Administrators immediately if there is a change in status.

I understand that proof of full-time student status may be requested at anytime. Failure to provide such documentation may result in the termination of benefits.

Employee's Signature: _____ Date: _____

Please return to: **Self Funding Administrators**
Post Office Box 6596, Annapolis, Maryland 21401