



**REQUIREMENT FOR DEPENDENT COVERAGE
OF ADULT CHILDREN (as of age 18)
GRANDFATHERED HEALTH PLANS**

Averett University Employee Health Plan

Coverage of adult children is provided **ONLY IF** that child does not have access to other employer-based coverage.

By signing this form I acknowledge the following:

- My adult dependent child (as of age 18) is not employed.
- My adult dependent child (as of age 18) is employed but does not have access to healthcare benefits through his/her Employer Plan or, if married, through the Plan of his/her spouse's employer, **and**

I have provided a letter from my dependent's Employer to verify that my dependent is not eligible for employer coverage.

Information obtained by use of this Acknowledgement may be used, without limitation, to, determine eligibility for benefits and benefit coverage, and coordination of benefits. **Falsifying information will immediately terminate coverage with no refund of premiums paid to the Plan and is grounds for immediate termination of employment.**

Any information obtained will not be released to any person or organization except to insurance companies providing reinsurance or other persons or organizations performing business or legal services in connection with Averett University or as may be otherwise lawfully required.

I understand that I have the right to change this acknowledgement at any time by notifying my employer in writing. I understand that I must notify my employer if my dependent becomes eligible for other employer-based coverage. I understand that any change is only effective after it is received and logged by Primary PhysicianCare, Inc.

I agree that a photographic copy of this acknowledgment shall be as valid as the original.

I understand that I am entitled to receive a copy of this acknowledgment.

I understand that this acknowledgment will expire when my employment terminates.

Signature of Employee or Legal Guardian

Date

Print Employee Name & ID Number

Dependent Name(s)