	CERTIFICATION OF OVER-AGE DEPENDEN	N OF OV	ER-J	AGE	DE	PEN	DEN	-	ELIGIBILITY FORM	BEL	ΥTI	FO	RM
Employee ID:					8	Work Location	ation:						
First Name:						Last Name:	ame:						
Mailing Address:						City:					State:		Zip:
Dependent Verification				17						3, 143		Š	
In accordance with Florida Statute 627.6562, certain children must meet specific eligibility requirements to be covered under the School District of Osceola County health services plan. In the event a claim is denied, it is the subscriber's sole responsibility to establish that the dependent(s) meet the requirements for continued eligibility. Additional Procession 1. This eligibility provision does not modify any other eligibility requirements. This eligibility provision does not modify any other eligibility requirements.	Statute 627.6562, certain c claim is denied, it is the su entation to ensure that a chi	nildren must meet bscriber's sole rea ld meets and con	specifi sponsibi	c eligibi ility to ex	lity requates tablish uch requared	iirement that the uiremen	s to be depend its. This	covere ent(s) r eligibili	d under neet the	the Sc require	thool D ements es not	istrict o for co	In accordance with Florida Statute 627.6562, certain children must meet specific eligibility requirements to be covered under the School District of Osceola County health services plan. In the event a claim is denied, it is the subscriber's sole responsibility to establish that the dependent(s) meet the requirements for continued eligibility. Additionally , tsDOC may request documentation to ensure that a child meets and continues to meet such requirements. This eligibility provision does not modify any other eligibility requirements.
(Rease refer to your Plan Document for more information.)	ocument for more informat	ion.)	1000	i c			<u>5</u>		700	2	5	2	ary outer enginemy requirements.
For an additional premium, children ages 26-30 are eligible to be covered as over-age dependents	children ages 26-30 are eli	gible to be covere	id as ov	er-age	depend	ents if:							
> They are unmarried, and													
> They have no dependent	They have no dependent children of their own, and												
> They live in Florida or atte	They live in Florida or attend school in another state,	, and											
> They have no other health insurance	h insurance.												
Please complete this section for any over-age dependents currently covered under the health insurance plan - All Fields Required:	n for any over-age depend	lents currently co	overed (under th	ıe healti	า insura	nce pla	n - All I	-ields F	Require	d.		
To enroll additional dep	To enroll additional dependents, you must contact People First	People First	Do they live in Florida?	y live rida?	Do they have other health insurance?	y have health ance?	Are they married?	they ied?	Do they have children of their ow n?	hey /e en of ww n?	Are they a full/part time student?	ney a rt time ent?	Name, city and term enrolled for any licensed school or university
Dependent's Name	Date of Birth	Relation	YES	₹	YES	8	YES	8	YES	8	YES	8	
I understand and agree that or deceive any insurer files s 817 234 Florida Statutes	t any misstatements may result in denial of benefits and/or termination of coverage. Any person a statement of claim or an application containing any false, incomplete, or misleading information. I hereby affirm and attest that the dependent(s) listed above meet the requirements of eligibility.	esult in denial of I application contact that the depend	oenefits aining a lent(s) l	and/or ny false isted ab	termina , incom	ition of a plete, oi ef the re	coveraç r mislea equirem	je. Any ding int	/ perso ormation	n who on is gu	know i	ngly an a felon	Lunderstand and agree that any misstatements may result in denial of benefits and/or termination of coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree pursuant to say a firm and affect that the dependent(s) listed above meet the requirements of eligibility.
Employee/Retiree Signature:	ture:										Date:		
	Please scan a	Please scan and email this form to insurance@osceolaschools.net or Mailing address: 831 Simpson Rd. #100, Kissimmee, FL 347.	n to insc impson	Irance@ Rd. #1	osceol	aschool:	s.net or FL 347		fax to (407) 943-7749. 44)43-77	49.		
	Mailir	Mailing address: 831 Simpson Rd. #100, Kissimmee, FL 34744	impson	Rd. #1	00, Kiss	immee,	FL 347	44					