

MichiganTech

FAMILY CONTINUATION RIDER APPLICATION

Employee: _____ SS# _____ - _____ - _____
Last First MI

Dependent: _____ SS# _____ - _____ - _____

Birth Date of Dependent: _____ / _____ / _____ Son _____ Daughter _____
Month Date Year

Expected date of Graduation: _____

Other Insurance? Yes _____ No _____ If Yes, name of company and group number: _____

If disabled, what is the disability (attach proof of eligibility for Social Security): _____

Disability Started: _____

Employee's Certification and Election of Coverage

I hereby apply for coverage for the dependent listed above as a Family Continuation Rider. I understand that this coverage requires a monthly contribution which will be deducted from my paycheck.

I certify that the child named above is a **student, unmarried, legally residing with me, and chiefly dependent upon me for support and maintenance.** I agree to notify the Benefits Office immediately of any change in status with my dependent child. I understand that if any health, dental or vision claims are paid after the dependent child becomes ineligible for coverage, I may be liable to repay the University for payments that are not recovered.

Employee's Signature

Date

BCBSM

PDAEDN

PDABENE

PZABCOV

PEAREVW