



CONTINUATION RIDER APPLICATION

Employee: _____ M# _____
Dependent: _____ M# _____
Birth Date of Dependent: _____ / _____ / _____ Son _____ Daughter _____
Month Date Year

Is there other insurance? Yes _____ No _____ If Yes, name of company and group number: _____

Employee's Certification and Election of Coverage

(Mark appropriate box)

I hereby apply for coverage for the dependent listed above as a:

[] Family Continuation Rider: I understand this coverage requires a monthly contribution which will be deducted from my paycheck. I certify the child named above is a student, unmarried, legally residing with me, and chiefly dependent upon me for support and maintenance.

Expected date of graduation: _____

[] Sponsored Dependent Rider: I understand this coverage requires a monthly contribution which will be deducted from my paycheck. I certify the child named above is dependent upon me for more than half of his/her support and has been reported as a dependent on my most recent federal income tax return. I also certify the dependent named above is related to me by blood or by marriage and resides in my household. Expected duration of coverage: _____

[] Disabled Dependent Rider: I certify the above named dependent child is disabled, eligible for social security benefits, unmarried, residing with me, and is chiefly dependent upon me for support and maintenance. What is the disability (attach proof of eligibility for Social Security): _____

I agree to notify the Benefits Office immediately of any change in status with my dependent. I understand if any health, dental or vision claims are paid after the child becomes ineligible for coverage, I may be liable to repay the University for payments that are not recovered.

Employee's Signature

Date

- [] AETNA [] PDAEDN [] PDABENE [] PZABCOV [] PEAREVW