



# ELIGIBILITY CERTIFICATION STATEMENT

(Please complete a separate form for each Adult Child you wish to enroll)

© Cook County, Illinois 458

## EMPLOYEE INFORMATION

Last Name First Name MI Social Security Number (Required) Work Phone #

Address City State ZIP Home Phone #

## ADULT CHILD INFORMATION

Name Social Security Number (Required) Date of Birth Sex M/F Other Coverage Y/N\*

\* If your adult child has other group health coverage, including Medicare, you must provide a copy of the front and back of the card to the Department of Risk Management.

CHECK ONE	CATEGORY	REQUIREMENTS AND DOCUMENTATION
<input type="checkbox"/>	Sponsored Adult Child	Unmarried child age 19 up to, but not including age 26. The employee is responsible for 100% of the cost of coverage. A certified birth certificate is required.
<input type="checkbox"/>	Veteran Adult Child	Unmarried child age 19 up to, but not including age 30 and must be an Illinois resident. The member is responsible for 100% of the cost of coverage. Proof of Illinois residency, Veterans' Affairs release form DD-214 (or equivalent) and a certified birth certificate are required.
<input type="checkbox"/>	Student Medical Leave of Absence	Unmarried child age 19 up to, but not including, age 22 enrolled as a student in an accredited school but is on a medical leave of absence or reduced course load to part-time due to a catastrophic illness or injury and eligible to be claimed as a dependent for tax purposes by the member. Maximum coverage period of one-year or attainment of age 22, whichever comes first. Monthly premiums initiate after this period ends. Clinical certification of need for part-time student status or medical leave from a licensed physician and notification from the School's registrar are required.

I authorize premiums as established annually to be deducted from my bi-weekly pay for the health plan in which I am enrolled. I understand that if my paycheck is insufficient or if I am not active on payroll, I must submit monthly premium. The information contained in this form is complete and true. I agree to abide by all health plan rules and agree to furnish additional information for enrollment or administration of the plan I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate. Falsification of the information contained on this form may result in discipline up to and including discharge. Additionally, Cook County Government may impose a financial penalty, including but not limited to, repayment of all premiums the program made on behalf of the enrolled individual, as well as expenses incurred by the program.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

OFFICE  
USE ONLY:

Effective Date: \_\_\_\_\_ Health Plan: \_\_\_\_\_  
 Processed By: \_\_\_\_\_ Date: \_\_\_\_\_