OVERAGE DEPENDENT CERTIFICATION

Date:	Group ID#:
	Subscriber Id#:
Address:	Dependent Name:
	Birth Date:
	Member Code:
	Cancellation Date:

According to our records, the dependent child named above will soon reach the eligibility age limit as defined in your Evidence of Coverage.

If our records are incorrect, or if we have not been informed of circumstances that would allow coverage to continue, it is extremely important that you inform us immediately.

If you believe your dependent is still eligible for coverage under your group plan, please check the appropriate box below and return this form, in its entirety, within 15 days. **Copies of documentation verifying your child's dependent status must be made available upon request.**

If you have any questions or need additional information, please contact your employer or Member Services in Southern California at 1-800-522-0088 and in Northern California at 1-800-638-3889.

If you do not return this form within 15 days of receipt, we will assume our records are correct, and the dependent's coverage will be cancelled as of the above cancellation date.

Please check one box below and sign. DO NOT TEAR OFF this portion.
☐ Heatlh Net's records are in error. My child's correct date of birth is ______________________________
☐ My Evidence of Coverage specifies continued eligibility to age ________ if my child is unmarried and dependent upon me for at least 50 percent of his or her support. My child is age ________ , unmarried, and dependent upon me for at least 50 percent of his or her support.
☐ My Evidence of Coverage specifies continued eligibility to age _________for full-time student dependents, as long as they are dependent upon me and unmarried. My child carries ________ semester units or equivalent hours and attends ________________________
☐ My child is disabled and incapable of self-substaining employment. At this time, my child **is** (or) **is not** under the Medicare program because of total disability. (*If this box is checked, Health Net will mail a Disabled Dependent Certification to you. Upon its receipt, please have your child's physician complete & return it to us.)*

SUBSCRIBER SIGNATURE:	DATE:
X	