OVER-AGE DEPENDENT ELIGIBILITY FORM

FrankCrum®
PAYROLL • INSURANCE • BENEFITS • HR

Member Social Sec #: ______________________________ Main Phone: ______________________________

First Name: ______________________________ Last Name: ______________________________

Mailing Address: ______________________________ City: ______________ State: ________ Zip: ________

Dependent Verification

In accordance with Florida Statute 627.6562, certain children must meet specific eligibility requirements to be covered under a FrankCrum health 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, FrankCrum 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.

Children ages 26-30 are eligible to be covered as over-age dependends if:

They are unmarried, and
They have no dependent children of their own, and
They live in Florida or attend school in another state, and
They have no other health insurance.

Please complete this section for any over-age dependents requesting coverage under the health insurance plan - All Fields Required:

Enter dependent information below:

Dependent's Name	Date of Birth	Relation	Do they live in Florida?	Do they have other health insurance?	Are they Married?	Do they have children of their own?	Are they a full or part-time student?	Name, City and term enrolled for any licensed school or university
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

I understand 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 s. 817.234, Florida Statutes. I hereby affirm and attest that the dependent(s) listed above meet the requirements of eligibility.

Employee Signature: ______________________________ Date: ______________________________

Please scan and email this form to Benefits@FrankCrum.com | Mailing address: 100 S. Missouri Ave., Clearwater, FL 33756