Cornell University

HR Services and Transitions Center
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Special Dependent Enrollment Form

ENDOWED HEALTH PLANS

This form must be completed when an enrollee/employee applies for coverage on behalf of a dependent child who is other than the enrollee's own child, legally adopted child, or step-child. For such a dependent to be eligible, the child must:

1. Be provided all medical expenses by the enrollee
2. Receive more than 50 percent of support from the enrollee
3. Reside permanently in the enrollee's home.

If you have a dependent who meets these criteria, please complete this form and **submit proof of support** (refer to question 2b). Please read carefully, respond accurately and initial your agreement to each piece of question 2 below, then sign and date the form. Contact the HR Services and Transitions Center at (607) 255-3936 or via email at hrservices@cornell.edu if you have questions.

Enrollee Name:_____ Effective Date:_____

Enrollee Address:_____

Enrollee Social Security Number:_____ Phone Number:_____

Email:_____

Dependent Name:_____ Dependent Date of Birth:_____

Dependent Social Security Number:_____

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1. What relationship is the dependent to you:_____

2. I certify the following (initial next to each statement)

   a. _____ Acting in place of the parent ("*in loco parentis*") for this dependent, I have assumed responsibility for medical expenses for the above named dependent until the child is age 26 or is otherwise no longer eligible for enrollment in Cornell University's health insurance plans.

   b. _____ I provide at least 50% of the support for this dependent. *Please supply documentation of this support: for example, papers indicating legal guardianship or a copy of your Federal tax return listing the individual as a dependent. If you do not claim the dependent on your tax return, we will accept a letter from a CPA or attorney that the dependent could be claimed on your tax return under current IRS regulations if you chose to do so.*

   c. _____ My home is the permanent legal residence of this dependent.

I certify that the above information is accurate. I understand that misstatement or misrepresentation may result in insurance coverage being void as of the effective date with no benefit payable.

Employee Signature:_____ Date:_____

Employee ID Number:_____