Annual Eligibility Certification for Plan Year 2026

Dependent Certification

Employees seeking Vision or Dental coverage for a **dependent between the ages of 20 and 23** shall certify dependent eligibility upon enrollment in the plan and on an annual basis. Upon verification, eligibility is permitted for the entire Plan year; provided the dependent continues to meet the Plan's eligibility rules**.**

Employee Name: _____ **Department:** _____

Dependent Name: _____ **Date of Birth:** _____ **Age in 2026:** _____

Eligibility Rule Verification for Dependent: (Check appropriate box)

Unmarried	☐ Yes	☐ No
Not employed on a regular full-time basis	☐ Yes	☐ No
Dependent on the covered employee or the covered employee's Spouse for more than 50% of their financial support (or if a stepchild: wholly dependent on the covered employee for financial support)	☐ Yes	☐ No
Claimed for tax exemption purposes under Section 152 of the Internal Revenue Code	☐ Yes	☐ No
Full Time Student at an accredited school	☐ Yes	☐ No

Name of School: _____

Address: _____
Street/PO Box City State Zip

If you answered yes to all of these questions, your dependent is eligible for Dental and Vision coverage. Please have the school named above complete the Verification of Full Time Student Status below. A statement from the school's clearinghouse may also be submitted with this certification as proof of full-time student status.

Full time student coverage continues only between semesters/quarters if the dependent is enrolled as a full-time student in the next regular semester/quarter and maintains dependent status as defined by the Plan. If the dependent withdraws from school or graduate's midyear, the dependent must be removed from the Plan by submitting a Universal Insurance Application and COBRA Personnel Action form. Refer to the Plan Document and Summary Plan Description for eligibility rules.

Misrepresentation regarding eligibility of any covered individual may result in retroactive termination of coverage and collection of paid claims, as well as disciplinary action and possible legal action as, and to, the extent permitted under applicable law.

All eligibility changes must be reported by completing and submitting a Universal Insurance Application within 30 days of the event/change to your insurance group representative.

I certify that the dependent named above, is considered a dependent based upon this Plan's current eligibility rules. I also authorize the school listed above to verify and/or release any information necessary to confirm full-time attendance for the purpose of establishing student status for the Dependent listed above.

Employee's Signature _____ Date _____

Dependent's Signature _____ Date _____

FOR SCHOOL USE ONLY: **SCHOOL STAMP**

Verification of Full Time Student Status

Please confirm the above noted Dependent's registration/enrollment at your institution:

☐ Full Time Student ☐ Part Time Student ☐ Not Enrolled

Enrollment Period: From: _____/_____/_____ To: _____/_____/_____

Registrar or Other School Official's Signature _____ Date _____