Employee Name: _____

SS# _____

Date: _____

Subject: **LIST OF DEPENDENTS**

According to the Consolidated Omnibus Reconciliation Act (Cobra) when your dependent children are dropped from coverage due to age, they may opt to continue on the university health insurance plan at their own expense for an additional 36 months. You must also notify HR in writing within 30 days of any life status change (including being dropped due to age).

IMPORTANT: It is your legal responsibility under COBRA to inform your children of this privilege. The university does not intend to assume this responsibility for you.

The following information will also be used for projecting coverage under our tuition plan. For this reason we are also asking for the name of your spouse (if you have one) and all children through age 25. If you do not have a spouse, or dependent child, please indicate that fact.

1._____ I have no dependents at this time (Please notify HR w/in 30 days if this changes).

_____	_____	_____
2. Spouse's Name	**Date of Birth**	**Social Security #**

Dependent children through age 25:

	Name	**Date of Birth**	**Relationship**	**SS #**
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

Signed _____ **Date:** _____