

**NATIONAL EMPLOYEES HEALTH PLAN  
APPLICATION FOR EXTENDED DEPENDENT COVERAGE  
FOR CHILDREN UP TO AGE 30 UNDER FL LAW 627.6562**

Employee Name \_\_\_\_\_ SSN (or other identifier) \_\_\_\_\_

Telephone Number \_\_\_\_\_ Email address \_\_\_\_\_

**Please list all of your children who are over the age of 26 and for whom you are requesting extended dependent coverage:**

Name	DOB/SSN	Name	DOB/SSN
_____	_____	_____	_____
_____	_____	_____	_____

*For EACH child listed above who is between the age of 26 and 30:*

Is each child unmarried? YES \_\_\_\_\_ NO \_\_\_\_\_

Is each child a resident of Florida? YES \_\_\_\_\_ NO \_\_\_\_\_

Is each child a full or part time student? School: \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

Does any child have a dependent of his or her own? YES \_\_\_\_\_ NO \_\_\_\_\_

Is any child provided coverage under any other health insurance policy or individual health benefits plan, or entitled to Social Security benefits? YES \_\_\_\_\_ NO \_\_\_\_\_

**If your child is deemed to be eligible for extended coverage on the basis of being a student, and your child goes on a “medically necessary leave of absence”, as defined in 29 U.S.C. §1185c (“Michelle’s Law”), that causes such child to lose student status for purposes of coverage, such child’s coverage will not be terminated due to the medically necessary leave of absence before the date that is the earlier of 1) one year after the first day of the medically necessary leave of absence or 2) the date on which coverage would otherwise terminate under the terms of this Plan.**

*I certify that the information provided above is true to the best of my knowledge. I understand that my dependent child(ren) between the ages of 26 and 30 must continue to meet eligibility requirements in order to continue coverage. I further understand that I or my dependent child may be required to pay an additional premium for continued coverage; to provide proof of eligibility and continued eligibility; that coverage may be considered a taxable benefit for my dependent child; and that if my dependent child, between the ages of 26 and 30, terminates coverage my dependent child will not be eligible for reinstatement prior to age 30 unless my child has been continually covered by other creditable coverage without a coverage gap of more than 63 days.*

**I HEREBY REQUEST COVERAGE FOR MY CHILD(REN) LISTED ABOVE AND EXERCISE MY OPTION TO HAVE MY CHILD(REN) BETWEEN THE AGES OF 26 AND 30 INSURED.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

*FOR PLAN USE ONLY:*

REQUEST GRANTED \_\_\_\_\_ REQUEST DENIED \_\_\_\_\_ REASON \_\_\_\_\_

## SUGGESTIONS FOR PLAN PROCEDURES:

Florida law requires insurers in the state of Florida to offer extended dependent coverage, if certain conditions are satisfied, to adult children up to the age of 30. Florida law thus requires that insured plans offer extended coverage for a longer period of time than required under the federal Affordable Care Act. The new federal law requires that all group health plans that offer dependent coverage for children allow coverage of such children up to the age of 26, *without any conditions*. For plans covered under both laws, therefore, adult children have the opportunity to remain on their parents' plan up to age 26 without meeting any conditions and up to age 30 if they meet the conditions set forth in the Florida law.

The Plan Administrator can continue to use established procedures for notifying participants when dependents are aging out of coverage because they have reached age 26, and include the application for extended dependent coverage with the notice if the participant's coverage is covered under the Florida law.

The information on the application should be sufficient for the Plan Administrator to determine if the eligibility requirements for extended dependent coverage under the Florida law are met. The requirements for coverage of adult children beyond age 26 are:

*A child between the ages of 26 and 30 must be:*

- unmarried
- AND either:
  - living in the state of Florida OR
  - a full or part time student.

AND the child:

- Must not have a dependent of his/her own,
- AND must not be provided coverage under any other health insurance policy or individual health benefits plan, or entitled to Social Security benefits.

The Trustees of each Plan can determine whether or not they would like to require that participants provide additional documents or other evidence in support of the representations made in the application or representations made in any verification/renewal documents. Application or renewal documents can be modified to include any such requests.

Once the Plan Administrator has determined whether children over the age of 26 are eligible for extended dependent coverage the Plan Administrator should be able to use notification procedures that are already in place in connection with extended dependent eligibility.

The Plan Administrator will need to monitor ongoing eligibility for adult children between the ages of 26 and 30 who are deemed eligible for extended coverage based on the Florida law. Before the ACA most plan administrators had developed procedures for monitoring extended dependent coverage for full time students over the age of 19. Although monitoring will no longer be required for children under the age of 26 plan administrators may be able to modify and use procedures to administer and monitor extended dependent coverage for adult children over the age of 26, particularly for any such dependents who are full time students. The attached form or something similar can be used for this purpose.

**NATIONAL EMPLOYEES HEALTH PLAN  
VERIFICATION OF ELIGIBILITY FOR EXTENDED DEPENDENT COVERAGE  
FOR CHILDREN UP TO AGE 30 UNDER FL LAW 627.6562**

Employee Name \_\_\_\_\_ SSN (or other identifier) \_\_\_\_\_

Telephone Number \_\_\_\_\_ Email address \_\_\_\_\_

**Please list all of your children who are over the age of 26 who are covered under the Plan under extended dependent coverage and for whom you request continued coverage:**

Name	DOB/SSN	Name	DOB/SSN
_____	_____	_____	_____
_____	_____	_____	_____

*For EACH child listed above who is between the age of 26 and 30:*

Is each child unmarried? YES \_\_\_\_\_ NO \_\_\_\_\_

Is each child a resident of Florida? YES \_\_\_\_\_ NO \_\_\_\_\_

Is each child a full or part time student? School: \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

Does any child have a dependent of his or her own? YES \_\_\_\_\_ NO \_\_\_\_\_

Is any child provided coverage under any other health insurance policy or individual health benefits plan, or entitled to Social Security benefits? YES \_\_\_\_\_ NO \_\_\_\_\_

**If your child is deemed to be eligible for extended coverage on the basis of being a student, and your child goes on a “medically necessary leave of absence”, as defined in 29 U.S.C. §1185c (“Michelle’s Law”), that causes such child to lose student status for purposes of coverage, such child’s coverage will not be terminated due to the medically necessary leave of absence before the date that is the earlier of 1) one year after the first day of the medically necessary leave of absence or 2) the date on which coverage would otherwise terminate under the terms of this Plan.**

*I certify that the information provided above is true to the best of my knowledge. I understand that my dependent child(ren) between the ages of 26 and 30 must continue to meet eligibility requirements in order to continue coverage. I further understand that I or my dependent child may be required to pay an additional premium for continued coverage; to provide proof of eligibility and continued eligibility; that coverage may be considered a taxable benefit for my dependent child; and that if my dependent child, between the ages of 25 and 30, terminates coverage my dependent child will not be eligible for reinstatement prior to age 30 unless my child has been continually covered by other creditable coverage without a coverage gap of more than 63 days.*

**I HEREBY REQUEST CONTINUED COVERAGE FOR MY CHILD(REN) LISTED ABOVE AND EXERCISE MY OPTION TO HAVE MY CHILD(REN) BETWEEN THE AGES OF 26 AND 30 INSURED.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

FOR PLAN USE ONLY:

ELIGIBLE \_\_\_\_\_ NOT ELIGIBLE \_\_\_\_\_ REASON \_\_\_\_\_