DEPENDENT CHILD(REN) ENROLLMENT FORM

The following information is needed regarding dependent children eligible for your health insurance coverage.

1. Are all of the children listed on your application form dependent upon you for support and maintenance?
   _____Yes _____No

2. Do all of the children listed on your application form make their primary residence with you?
   _____Yes _____No

   If not, does a divorce decree or court order make provision as to who is responsible for health insurance?
   _____Yes _____No
   If yes, please provide a copy of the section of the divorce decree or court order relating to health insurance coverage for the above referenced dependent(s).

3. Are all of the children listed on your application unmarried? _____Yes _____No
   If No, please provide the date_____

The State of Illinois has passed legislation (HB5285, Public Act 95-0958) regarding Dependent Coverage Age Limits. This new law applies to all fully-insured individual and group accident and health plans, individual and group HMO plans, state employee plans and to self-funded county, municipal and school plans in Illinois. This law is effective June 1, 2009:

1. Dependent coverage eligibility is extended to age 26 for unmarried children (instead of age 19) regardless of student status.

2. Dependent coverage eligibility is extended to age 30 for dependents who are an Illinois veteran and received a release other than a dishonorable discharge. These individuals will be required to provide documentation from the Dept. of Veterans Affairs.

4. Is your dependent totally and permanently disabled? _____Yes _____No
   If yes, is dependent eligible for Medicare or Medicaid? _____ Yes _____ No
   Effective date: Hospital ___/___/___ Medicare #_____
   Medicare ___/___/___ Medicaid # _____

I certify that the answers given above are true and correct. I understand that the plan will rely upon the accuracy and truthfulness of this information and that if I made any false statement, the plan will be entitled to declare my coverage void and refuse allowance of benefits for me and all persons entitled to coverage under my contract.

Signature Date