

Please send to:

Dependent Certification United Concordia Companies

PO Box 69417

Harrisburg PA 17106-9417 Fax number: 1-800-329-9093

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent. **Incomplete or illegible forms will be returned to the sender, resulting in delayed processing.**

SECTION A: GENERAL INFORMATION (To be completed by Employee)		
1. Name of Employee (print - last, first & middle initial)		2. Contract ID Number (Such as SSN)
3. Employee's Address (number, street, city, state & zip code)		
4. Dependent Name (print - last, first & middle initial)		5. Dependent's Birthdate (mm/dd/year)
6. Dependent's Relationship to Employee Son Daughter Other	7. Dependent's Marital Status Single Married	If dependent is married, provide date of marriage (mm/dd/year)
8. Is dependent currently covered under a medical plan? Yes No	If Yes, provide name of insurance company	
9. Is dependent currently covered under another dental plan? Yes No	If Yes, provide name of insurance company	
SECTION B: STUDENT DEPENDENT CERTIFICATION (To be completed by Employee)		
1. Name of school in which dependent is enrolled 2. Type of school (i.e., college, trade, etc.		
3. Student enrolled Full-Time Part-Time Post-Graduate	Will the dependent be graduating within 12 Yes No	
	If "Yes," please provide the expected graduation	
Number of Credits	delayed processing and/or termination of dependent coverage.	
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.		
Signature of Employee Phone N	umber Email Address	Date Signed
SECTION C: DISABLED DEPENDENT CERTIFICATION (To be completed by Physician)		
I. is dependent now incapable of self-support because of a disability? Yes No	2. Dependent's age when disability occurred	
3. Nature of disability (please provide as much detail as possible)		
4. Prognosis (estimate in months or years)		
5. Name of Primary Cate Physician (print or type)	6. Address of Physician (print or type)	Alternative Co.
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.		
Signature of Physician	Date Signed	
SECTION D: DEPENDENT NO LONGER ELIGIBLE (To be completed by Employee) PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INCLIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE. LACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.		
Signature of Employee Inelieit	ble Effective Date	Data Signad
C DER 1208	OIC LITECTIVE DATE	Date Signed