

**EMPLOYEE NAME:** \_\_\_\_\_

### DEPENDENT ELIGIBILITY REQUIREMENTS

In order to ensure that dependents enrolled in the health plans meet the eligibility requirements, we are requesting eligibility confirmation for the dependents you want to enroll. Eligible dependents are defined in our Summary Plan Description as:

1. Your lawful spouse
2. Your children who are:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under the CDI plan, or while covered as a dependent under a prior plan with no break in coverage between the two plans.

The term "child" means a child born to you or a child legally adopted by you. It also includes a stepchild, a foster child or a child for whom you are the legal guardian.

### CONFIRM DEPENDENT ELIGIBILITY

Dependent Name	Relationship (spouse / child)	Gender (male / female)	DOB	Does this dependent meet the definition of an eligible dependent?	
				Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

### SIGNATURE AND DATE

By my signature on this form, I certify and warrant to Cascade Designs that all dependent information on this form is true, correct, and current as of the date signed. I understand that any attempt to cover an ineligible dependent will subject me to appropriate disciplinary action.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date