Health Net®

Overage Dependent Certification

Date:

Address:

Group #:

Plan:

ID #:

Certificateholder Name:

Dependent Name:

Birth Date:

Cancellation Date:

According to our records, the dependent child named above will soon reach the eligibility age limit as defined in your Health Net of California Evidence of Coverage or Health Net Life Insurance Company Certificate of Insurance.

If our records are incorrect, or if we have not been informed of circumstances that would allow coverage to continue, it is extremely important that you inform us immediately.

If you believe your dependent is still eligible for coverage under your group plan, please check the appropriate box below and return this form to Health Net, in its entirety, within 60 days.

Copies of documentation verifying your child's dependent status must be made available upon request.

If you have any questions or need additional information, please contact your employer or Member Services (In Southern California call 1-800-522-0088 and in Northern California call 1-800-638-3889).

If you do not return this form within 60 days of receipt, we will assume our records are correct, and the dependent's coverage will be cancelled as of the above cancellation date.

Please check all applicable boxes below and sign. PLEASE DO NOT TEAR OFF this portion.

☐ My child meets the criteria specified in my Evidence of Coverage or Certificate of Insurance as indicated by the criteria checked below, and should remain active under the coverage he/she is currently enrolled in:
☐ MEDICAL ☐ DENTAL ☐ VISION

☐ My child is: ☐ 50% ☐ 100% dependent upon me for support. Your plan may require that the dependent is enrolled as a full-time student.

☐ Health Net's records are in error. My child's date of birth is_____

☐ My child carries _____ semester units* and attends _____

(NUMBER OF UNITS CARRIED) (FULL NAME OF SCHOOL ATTENDED)

*If less than 9 units and considered full time student, please provide supplemental documentation for school.

☐ My child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon me for support and maintenance. At this time, my child ☐ is or ☐ is not under the Medicare program because of total disability. *(If this box is checked, Health Net will mail a Disable Dependent Certification to you. Upon receipt, please have your child's physician complete and return it to us.)*

Subscriber Signature	Date
X_____	

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Return this entire completed form in the enclosed postage-paid envelope or fax to (818) 676-7411.