



Health Net®

## Individual & Family Plans Overage Dependent Certification

Date:

Group #:

Plan:

Subscriber ID #:

Address:

Subscriber 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 Individual & Family Plan HMO Plan Contract and Evidence of Coverage or Health Net Life Insurance Company Individual & Family Plan PPO Policy.

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 Individual & Family Plan, please check the appropriate box below and return this form in its entirety, **within 60 days from the date of this letter.**

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

**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 Health Net at (800) 839-2172.

If your child is no longer eligible for coverage as a dependent, he/she may elect to remain covered by the same plan under his/her own Policy. Underwriting is not required as long as the application is submitted and returned to Health Net within 31 days' following the dependent's birthday. Please contact your agent or Health Net at (800) 909-3447 (option 2) to enroll.

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

The birth date noted above for my dependent is incorrect. My child's date of birth is \_\_\_\_\_.

My Individual & Family HMO Plan Contract and Evidence of Coverage or PPO Policy specifies continued eligibility through age 23 for full-time student dependents. A full-time student is one taking at least nine semester units (or equivalent hours) in a qualified college, university, or vocational school, as determined by Health Net.

My child carries \_\_\_\_\_ units and attends \_\_\_\_\_.

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  is not under the Medicare program because of total disability. (Please attach a letter from the child's physician explaining the diagnosis, extent of disability and prognosis.)

Comments:

Subscriber Signature

X \_\_\_\_\_

Date

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**Return this entire completed form in the enclosed postage-paid envelope or fax to (916) 935-4522.**