Intent to Claim Dependents

I, ______________________________, hereby state the dependent(s) listed below

☐ Reside in my home

☐ Do not reside in my home

and are eligible to be claimed as my dependent(s) on my Federal Income Taxes, Form 1040. I understand it is my responsibility to remove the dependent(s) when they no longer live with me and/or are not eligible to be claimed as my tax exemption.

Name	Relationship	Date of Birth	Social Security Number

<u>Note:</u> A Social Security Number is required for any dependent(s) being added to your health care coverage. If the dependent(s) listed above has a Social Security Number and it is not indicated, it must be written in the appropriate area on this form in order for this dependent(s) to be eligible to be enrolled for coverage. If the dependent has not yet been assigned a Social Security Number, it must be obtained and reported to the Company within six (6) months from the effective date of coverage or the dependent will be removed from your coverage.

I understand and agree to repay promptly all monies for claims for premiums incurred for any ineligible person(s) I enroll, and for services my dependent(s) or I were not entitled to, as determined by the Company. If I fail to repay such monies promptly after the Company has mailed a written notice to my last known address stating that such monies are owed and payable, I authorize the Company to make an appropriate deduction or deductions for recovering such overpayments from any present or future compensation payable by the Company until such monies are fully repaid.

I declare the above information to be true, and accurate, to the best of my knowledge.

______________________ State of Residence: ______________________

Employee Signature

______________________ ______________________

Date Employee Social Security Number

All areas of the form must be completed and the form must be signed before the above listed individual(s) can be added to your coverage.