Aetna® Special Dependent Form

Attn: Group Insurance Administrator

Control Number: _____

Employee Name: _____

Employee Social Security Number: _____

Dear Employee,

Thank you for your request concerning coverage for a Special Dependent Child. To determine eligibility, please send us the following information.

1. What is the full name and relationship of the Special Dependent Child?

   Name _____ Relationship _____

2. What is the date of birth of the Special Dependent Child? *(mm/dd/yyyy)* _____

   NOTE: If the Special Dependent Child is age 19 or over, the Special Dependent Child must be attending school on a regular basis **or** must meet the definition of a dependent per the plan of benefits.

3. When did the child become your Special Dependent Child? *(mm/dd/yyyy)* _____

4. Is the Special Dependent Child married? ☐ Yes ☑ No

IF THE SPECIAL DEPENDENT CHILD IS YOUR BIOLOGICAL CHILD OR STEPCHILD, SKIP THE REMAINING QUESTIONS AND SIGN BELOW.

5. When did the Special Dependent Child become dependent upon the employee for support? *(mm/dd/yyyy)* _____

SKIP QUESTION **6** IF THE EMPLOYEE RESIDES OR WORKS IN THE STATE OF FLORIDA, LOUISIANA, MASSACHUSETTS, TEXAS OR WISCONSON ***AND*** THE SPECIAL DEPENDENT CHILD IS THE EMPLOYEE'S GRANDCHILD.

6. Do the employee and the Special Dependent Child live in a parent-child relationship at the same address? ☐ Yes ☐ No

7. Is the Special Dependent Child supported by the employee? (i.e., Is the employee able to claim the Special Dependent Child as an exemption for federal income tax purposes?) ☐ Yes ☐ No

   NOTE: If the Special Dependent Child is a Foster Child, the Foster Child must live with you for the entire year and must pass the IRS Support Test in order to be claimed as an exemption on your federal income tax.

This is to certify that the above is accurate. I understand that misstatement or misrepresentation may result in insurance coverage being void as of the effective date with no benefits payable.

Employee Signature _____ Date _____