UNITED CONCORDIA
Insuring America's Dental Health

Please send to: Dependent Certification
United Concordia Companies
PO Box 69417
Harrisburg PA 17106-9417
Fax number: 1-800-329-9093

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent. **Incomplete or illegible forms will be returned to the sender, resulting in delayed processing.**

SECTION A: GENERAL INFORMATION *(To be completed by Employee)*

1. Name of Employee (print - last, first & middle initial)

2. Contract ID Number (Such as SSN)
___ ___ ___ ___ ___ ___ ___ ___ ___

3. Employee's Address (number, street, city, state & zip code)

4. Dependent Name (print - last, first & middle initial)

5. Dependent's Birthdate (mm/dd/year)

6. Dependent's Relationship to Employee
☐ Son ☐ Daughter ☐ Other

7. Dependent's Marital Status
☐ Single ☐ Married

If dependent is married, provide date of marriage (mm/dd/year)

8. Is dependent currently covered under a medical plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

9. Is dependent currently covered under another dental plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

SECTION B: STUDENT DEPENDENT CERTIFICATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled

2. Type of school (i.e., college, trade, etc.)

3. Student enrolled
☐ Full-Time ☐ Part-Time ☐ Post-Graduate

_____ Number of Credits

Will the dependent be graduating within 12 months?
☐ **Yes** ☐ **No**

If "Yes," please provide the expected graduation date: _____

Failure to provide the expected graduation date may result in delayed processing and/or termination of dependent coverage.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee | Phone Number | Email Address | Date Signed

SECTION C: DISABLED DEPENDENT CERTIFICATION *(To be completed by Physician)*

1. Is dependent now incapable of self-support because of a disability?
☐ Yes ☐ No

2. Dependent's age when disability occurred

3. Nature of disability (please provide as much detail as possible)

4. Prognosis (estimate in months or years)

5. Name of Primary Care Physician (print or type)

6. Address of Physician (print or type)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Physician | Date Signed

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.

Signature of Employee | Ineligible Effective Date | Date Signed