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Dependent Child Eligibility Form

This form must be completed for each child who has attained age 19.

Note: Every item must be completed before eligibility can be processed/confirmed! (please print in ink or type)

Plan Name: _____

Enrollee Name: _____ ID/SSN #: _____

Child Name: _____ Soc Sec #: _____ Date of Birth: _____

Child's Employment Based Healthcare Coverage

Is the child employed? Yes (please complete this section) No (skip this section)

Name of employer: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Does this employer offer healthcare coverage? Yes No

If so, is child eligible for this coverage? Yes No

If not, why not? Working part-time No Open Enrollment Period

Open Enrollment Period already passed Other _____

If eligible, has child enrolled in this coverage? Yes No N/A, not eligible

Child's Spouse Employment Based Healthcare Coverage

Is the child married? Yes (please complete this section) No (skip this section)

Is the child's spouse employed? Yes No (skip the rest of this section)

Name of employer: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Does this employer offer healthcare coverage? Yes No

If so, is child eligible for this coverage? Yes No

If not, why not? Working part-time No Open Enrollment Period

Open Enrollment Period already passed Other _____

If eligible, has child enrolled in this coverage? Yes No N/A, not eligible

Student Healthcare Coverage

Is the child a student? Yes No

Name of school: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Is child eligible for coverage as a student? Yes No

If eligible, has child enrolled in this coverage? Yes No N/A, not eligible

I hereby certify that the above answers are true and complete to the best of my knowledge and are the basis under which benefits are provided under this Plan. **I agree to notify the Plan in the event of a change in any of the information requested above.**

Signature of Child

Date

Signature of Enrollee

Date