PINNACLEHEALTH

Adult Dependent (between the ages of 19-26)
Medical Plan Eligibility Form

Pinnacle Health System provides medical coverage to lawful spouses and adult dependents of Pinnacle Health System employees, provided that the spouse or dependent is not offered medical coverage through any source (with the exception of Medicare), **or** the family member is required to contribute more than half (50%) of the total cost of the employer's premium for coverage from his/her employer. If your spouse and/or adult dependents are employed, he or she must have Section 2 completed by their employer's Human Resources Representative or Manager. Section 2 does not require completion if your spouse or adult dependent is employed by PinnacleHealth or is not employed. Please retain a copy of this completed form for your records. Please visit the PH intranet, under Benefits, for more information.

Section 1 – Pinnacle Health System Employee

This section must be completed by the Pinnacle Health System Employee.

Employee Full Name- First, Middle Initial, Last	Employee Work Phone	Alternative Contact Number (Cell or Home)
Employee ID Number	Last Four digits of Employee Social Security Number	
Adult Dependent Name - First, Middle Initial, Last	Last Four digits of Dependent's SSN	Dependent's Date of Birth

Gender of Adult Dependent: □ Male □ Female

My adult dependent is:

□ Not Employed □ Self-Employed □ Enrolled in Medicare

□ Employed but not offered medical benefits through his employer

□ Employed and is required to pay more than 50% of the total cost of the employer's premium for coverage from his/her employer

Name and Address of Adult Dependent's Employer	Telephone Number of Employer (including area code)

I solemnly affirm that the information provided above is true, accurate, and complete. I understand that providing false information may result in health coverage cancellation and/or corrective action up to and including termination of employment in accordance with the provisions of my medical plan and/or Pinnacle Health System policies.

Employee Signature ____________________ Date ____________________

Section 2 – Adult Dependent's Employer Section**

This section must be completed by an Authorized Representative of the above named Adult Dependent's Employer. PinnacleHealth reserves the right to contact the person completing this form to verify legitimacy.

1. **Is medical coverage available to your employee?** □ **Yes** □ **No**
2. **Does your employee contribute more than half (50%) of the total cost of the employer's premium for medical coverage?** □ **Yes** □ **No (If answer is no, then they are not eligible for PH medical)**

Name and Title of the Authorized Representative completing this form (please print):

Telephone Number and E-Mail Address of Authorized Representative completing this form (please print):

Authorized Representative Signature Date Signed

*****Please have employer fax this form back to PinnacleHealth Benefits Department at (717) 231-8659*****