

High Desert & Inland Employee-Employer Trust Certification of Child's Coverage Eligibility

If your otherwise eligible child between the ages of 19 to 26 has group health coverage available through another employer (other than through another parent's employment), your child is not allowed to enroll in the Plan. The High Desert & Inland Employee-Employer Trust (the Plan) is a grandfathered plan as defined under regulations set forth by federal law. As a grandfathered plan, our obligation to make health coverage available for a child until age 26 is limited by a special rule. Plan coverage generally will not be allowed if a child is eligible for employment-based health benefits except through a parent. (**Example:** If you are the mother, health coverage available from your child's father's employer does not make the child ineligible. So, you can enroll your child even though he or she has coverage available through the father. But, if your child has his or her own job, or your child's spouse has a job, and your child is eligible for health benefits as a result, you may not enroll that child. The child is not eligible.)

You must complete the information listed below for each child, between the ages of 19-26, and return this form to the School District Office to certify whether or not other coverage is available. In addition, if your child enrolls now, but later becomes eligible for coverage under the group health plan of another employer, you must notify the School District Office of this new eligibility in writing within 31 days.

Employee Name _____ SSN _____

Child's Name _____ SSN _____

- My child is **eligible** for other employer-based health coverage (other than through a parent). Please sign below and provide a description of the source of the other health coverage (such as the name of the other employer or plan): _____.
I further understand that if such other coverage is lost, and my child is still otherwise eligible for coverage under this plan, then my child can enroll in this Plan under HIPAA special enrollment rules as prescribed under federal law.

Signed _____ Date _____

- My child is **not eligible** for other employer-based health coverage. If your child is not eligible for other coverage you **must** sign and return the declaration below within the timeframe required by the plan for enrollment forms to be returned before your child may be covered.

I hereby certify, under penalty of perjury, that my child is not eligible for his or her own employer-based group health coverage benefit. I further certify that should my child become eligible for other group coverage at a future date that I will notify the School District Office in writing within 31 days to notify the plan of such eligibility. I further understand that any misrepresentation on this form or due to a failure to notify the School District Office of changes will constitute gross misconduct and can result in termination of my employment and also the potential loss of COBRA coverage as allowed by federal law.

Signed _____ Date _____