COUNTY OF ONONDAGA

DEPARTMENT OF PERSONNEL | EMPLOYEE BENEFITS DIVISION

John H. Mulroy Civic Center
421 Montgomery Street, 15th Floor
Syracuse, New York 13202-2959
Phone: (315) 435-3498 | Fax 435-2869 | E-mail: EmployeeBenefits@ongov.net | Web address: www.ongov.net

ATTENTION: ***If your dependent lost dental coverage and you are re-enrolling your dependent in coverage, or a new hire adding their dependent to dental, this form along with an Employee Benefits Enrollment Application and School Schedule are required.***

To be eligible for Dental coverage, Dependent Children must certify that they are attending high school, a licensed trade school, or an Accredited Institution of Higher Education as a Full-Time Student prior to their 19th birthday semi-annually thereafter until their 26th birthday or until the Dependent Child no longer attends school as a Full-Time Student, whichever is earlier. If student status changes during the certification year, you must notify Employee Benefits at the time your dependent no longer attends school**.**

Employee Name: _____ UMR Member Id: _____

Name of Employer: Onondaga County or OCC Employment Status: Active or Retired

Dependent Name: _____ Dependent Birth Date: ____/____/____ Relationship to Subscriber: _____

1. Is the dependent covered under any other Dental Insurance Contract? Yes No.
If yes please provide the name of the insurance company, Identification No and phone number:
Name: _____ Id No: _____ Phone No: _____

2. Is the dependent married? Yes No If Yes, Marriage Date: __/__/____

This section is for High School Students Only

3. Is the dependent currently attending High School full-time? Yes No
a. If the dependent is no longer attending High School, please provide the date in which he/she stopped attending school or became a part-time student: ____/____/____
b. What is the anticipated graduation date? ____/____/____
c. After graduating from High School will the dependent be attending College? Yes No

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This section is for College Students Only

4. Is the Dependent currently attending College as a full-time Student? Yes No
a. If yes, what is the name of the College/University the dependent is attending? _____
b. Has the student continuously been enrolled and attending school? Yes No
c. Please provide the first date class began for this semester: ____/____/____
c. What is the anticipated graduation date? ____/____/____
d. If no, please provide the date in which he/she stopped attending school or became a part-time student: _____

5. After graduation will the dependent be attending Graduate School? Yes No Unknown

I attest that the information shown above is true and complete. I agree to advise the County of Onondaga promptly of any changes in my child's dependent student status. I understand that any misrepresentation in the information I have provided above will permit the Onondaga County Dental Plan to terminate the dependents membership and seek any other legal remedies available to the County of Onondaga.

Subscriber Signature: _____ Date: _____

Office Use Only: Certified Through _____Authorized Signature _____Date: _____