

MARITAL STATUS ATTESTATION FORM

This form must be completed, signed, and returned to Network Health Plan's (NHP) Group Administration Department along with a Membership Application & Change form. As with any special enrollment, the request to add the following dependent must be made within 31 days of the qualifying event.

Mandatory Insurance Requirement Information

I, _____, attest that as of this date, my dependent,
(employee name)

_____, is between the ages of 19 and 27, is unmarried,
(dependent name)

and not eligible for coverage under a health plan through his/her own employer that charges the same or less in premiums than the applicable premium charged for their coverage under my employer's plan and therefore is eligible under my insurance policy with Network Health Plan.

I understand and acknowledge that any person, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer, submits a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act

By signing this form, I certify the information is complete and correct.

Employee Signature

Date