

Immediate Attention Required!

To the best of your knowledge, please answer the following for coverage year 2002. If there is any change in your dependent's eligibility after this questionnaire is completed, notify your payroll/personnel office as soon as the change occurs.

1. Is the dependent child your natural, step or adopted child, or a child who became the subscriber's permanent legal ward prior to age 19? Yes _____ No _____
2. Is the child unmarried and dependent upon you or the other parent for at least 50% of his or her support and does he or she meet the support tests as a dependent for income tax purposes (whether or not the child is actually claimed)? Yes _____ No _____

If the dependent has married, provide date of marriage: _____
(Note: Coverage ends on the last day of the month in which the marriage occurs.)

3. In 2002, will the dependent child be enrolled in, and attending as a full-time student, an institution that provides a schedule of classes and whose principal activity is the procurement of an education?
Yes _____ No _____

If yes*: Name of school: _____

Anticipated graduation date: _____

If no: Date full-time attendance ceased: _____

*If your response to question 3 is yes but the dependent does not return to school as a full-time student during the spring semester of 2002, you must notify your payroll representative immediately. Failure to do so may result in unpaid claims as this individual may no longer be considered an eligible dependent on your health insurance contract.

4. Is the dependent child incapable of self-support due to a mental or physical disability which is expected to be of long-continued or indefinite duration (generally one year or more)?
Yes _____ No _____

If yes, indicate the diagnosis and provide the name and telephone number of the attending physician who can be contacted to verify the disability and/or obtain a physician's statement:

Your child will continue to be covered as your dependent if the answers to questions 1. and 2. above are yes and the child is either a full-time student (item 3) or is disabled and incapable of self-support (item 4), as determined by the plan. You may appeal to ETF if you disagree with the plan's decision as to whether the dependent is eligible.

If you have any questions regarding this form, please call our _____ department at _____.

To the best of my knowledge all statements and answers above are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. I understand that fraud or material misrepresentation of the child's eligibility for coverage will result in termination retroactive to the date eligibility was lost and I or my dependent will be responsible for the cost of service provided during the period when coverage was erroneously in effect.

Subscriber's Signature

Date