

## Over-Age CHILD Questionnaire



Employee Name: \_\_\_\_\_

Employee SS#: \_\_\_\_\_

**Instructions:** Complete this form, then sign and date it.  
Return (with copies of any requested documents) to:  
Creative Benefits, Inc., P.O. Box 1928, Vista, CA  
92085-1928 or fax to 760-631-3812

Please answer the following questions as they relate to your covered child who is over age 18.

1. Please enter the covered child's name:	
2. Please enter the covered child's birth date:  <b>YOU MAY DISREGARD THIS QUESTION IF THE COVERED CHILD'S BIRTH DATE AND SOCIAL SECURITY NUMBER ARE PRE-PRINTED ON THE AUTHORIZATION FORM.</b>  Please enter the covered child's Social Security Number:	____/____/____  ____
3. What percentage of this covered child's financial support do you currently provide?	<50%    50-99%    100%
4. Is the percentage of support in #3 likely to change within the next year? If yes, enter the date support is likely to change:	Yes    No ____/____/____
5. Does this covered child qualify as your dependent for federal income tax purposes?	Yes    No
6. Is this covered child currently enrolled as a student or between school terms?  If yes, please answer the following: a. What is the name of the education institution your child is attending?  b. What percentage of a full-time load does your child carry?  c. What is the month and year you expect this child to graduate?	Yes    No  _____  1% - 25%                  51% - 74% 26% - 49%                75% - 99% 50%                            100%  ____/____
7. Does this child currently have a disability that makes him/her incapable of self-sustaining employment or incapable of self-care?	Yes    No
8. Has this child ever been married? If yes, please provide the following dates, if applicable:  Date of marriage:  Date of legal separation, divorce or annulment:	Yes    No  ____/____/____  ____/____/____
9. Is this child in military service? If yes, please provide the following information:  Branch of service:  Date entered active duty:  Discharge date (if still active, write N/A):	Yes    No  _____  ____/____/____  ____/____/____
10. Is there other information you believe is important for the health insurer to know if evaluating your request to continue coverage for this child? If yes, provide additional information on reverse.	Yes    No
11. Does this child live with you?	Yes    No

**The above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date