



DEPENDENT INFORMATION REQUEST FORM

An Eligible Dependent for the University of Nebraska medical, dental and vision care insurance plan includes:

Your spouse:

- Husband or wife, as recognized under the laws of the state of Nebraska
- Common-law spouse if your common-law marriage was contracted in a jurisdiction recognizing a common-law marriage

Your unmarried children:

- Natural-born or legally adopted child who has not reached the limiting age of 19 (age 24 if a full-time student)
- Stepchild who is living in your home and is chiefly dependent on you for financial support (must be claimed as an IRS dependent), and who has not reached the limiting age of 19 (age 24 if a full-time student)
- Child for whom you are the legal guardian and who has not reached the limiting age of 19 (age 24 if a full-time student)
- Mentally or physically handicapped child who has attained the limiting age of 19
- Dependent children who are students (ages 19 through 23) must receive over half of their financial support from you

Employee Name _____ Personnel Number _____
Last First MI (located on pay advice)

Campus Address _____ Zip Code _____

Campus Phone _____ Email Address _____

SPOUSE

Name: _____ Gender: M F
Last First MI

Date of Birth: ___/___/___ Social Security Number: ___-___-___
Month Day Year

Coverage Enrolled For: Medical _____ Dental _____ Vision _____

DEPENDENT CHILD NO. 1

Name: _____ Gender: M F
Last First MI

Date of Birth: ___/___/___ Social Security Number: ___-___-___
Month Day Year

Coverage Enrolled For: Medical _____ Dental _____ Vision _____

Relationship to You: Natural-born or Legally Adopted _____ Stepchild _____ Legal Guardian _____

Complete the Following only if Dependent Child is Between Ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes _____ No _____
 If Yes: Name of School _____
 Number of Credit Hours for Current Semester/Quarter _____

Additional Dependent Children may be added on the back of this form.

I certify the statements on this form are true and any intentional misrepresentation is grounds for disciplinary action including potential termination of employment. If I am insuring a Stepchild, I certify that they 1) live in my home and 2) are dependent upon me for financial support (must be claimed as an IRS dependent).

Employee Signature

Date

DEPENDENT CHILD NO. 2

Name: _____ Gender: M F
Last First MI

Date of Birth: ___/___/___ Social Security Number: ___-___-___
Month Day Year

Coverage Enrolled For: Medical ___ Dental ___ Vision ___

Relationship to You: Natural-born or Legally Adopted ___ Stepchild ___ Legal Guardian ___

Complete the Following only if Dependent Child is Between Ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes ___ No ___
If Yes: Name of School _____
Number of Credit Hours for Current Semester/Quarter _____

DEPENDENT CHILD NO. 3

Name: _____ Gender: M F
Last First MI

Date of Birth: ___/___/___ Social Security Number: ___-___-___
Month Day Year

Coverage Enrolled For: Medical ___ Dental ___ Vision ___

Relationship to You: Natural-born or legally adopted ___ Stepchild ___ Legal Guardian ___

Complete the Following only if Dependent Child is Between Ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes ___ No ___
If Yes: Name of School _____
Number of Credit Hours for Current Semester/Quarter _____

DEPENDENT CHILD NO. 4

Name: _____ Gender: M F
Last First MI

Date of Birth: ___/___/___ Social Security Number: ___-___-___
Month Day Year

Coverage Enrolled For: Medical ___ Dental ___ Vision ___

Relationship to You: Natural-born or Legally Adopted ___ Stepchild ___ Legal Guardian ___

Complete the Following only if Dependent Child is Between Ages 19 - 24:

Is Dependent Child a Full-Time Student? Yes ___ No ___
If Yes: Name of School _____
Number of Credit Hours for Current Semester/Quarter _____

Additional Dependent Information Request Forms are available on the University of Nebraska benefits Web page at www.nebraska.edu/benefits.