RESEARCH FOUNDATION
THE CITY UNIVERSITY OF NEW YORK
555 West 57th Street, New York, N.Y. 10019
(212) 417-8300

STATEMENT FOR DEPENDENT'S PARTICIPATION IN HEALTH BENEFITS PROGRAM

This form must be completed when an eligible employee applies for coverage on behalf of a spouse and/or child(ren). Required documentation must accompany this form.**

This form is to be completed by the employee. Please PRINT all entries.

_____ ____ ____ ____-____ ____-____ ____ ____ ____
Employee's Name **Social Security Number**

____ ____ ____ ____ ____ ____ _____
Employee ID # **E-Mail Address**

Employee's Home Address:_____

Telephone #s: _____
Home **Business** **Mobile**

Work Location (Campus)_____**Department or Office:**_____

Dependent's Full Name	Relationship to Employee	Social Security # of Dependent	Date of Birth of the Dependent
	Spouse*		
	☐**Son** ☐ **Daughter**		
	☐**Son** ☐ **Daughter**		
	☐**Son** ☐ **Daughter**		
	☐**Son** ☐ **Daughter**		
	Other: Specify relationship		

***If spouse is to be covered, please indicate date of marriage:**_____.

This information is being requested for the principal purpose of determining eligibility of individuals to participate in the RESEARCH FOUNDATION'S Health Insurance Program and to maintain up-to-date records for covered employees. If the necessary documentation **(**marriage certificate, birth certificate, court order, adoption papers, or proof of domestic partnership**) is not supplied with this form and your enrollment application, the spouse and dependent(s) listed cannot enroll in any health plan provided through the RESEARCH FOUNDATION.

Presentation of materially false information in support of an insurance application or claim is prohibited by Article 176 of the Penal Law.

I attest, under the penalty of perjury, that the information given above is correct and complete.

Date:_____Employee Signature_____

If you have any questions regarding this statement, contact your **Client Services Representative**