QUALIFIED MEDICAL CHILD SUPPORT ORDER CERTIFICATION FORM

NOTE: IF YOUR SUBSCRIBER CURRENTLY DOES NOT HAVE FAMILY COVERAGE, A COMPLETED MEMBERSHIP APPLICATION FOR FAMILY COVERAGE MUST ACCOMPANY THIS FORM.

PART I: IF THE QUALIFIED MEDICAL CHILD SUPPORT ORDER (AND A MEMBERSHIP APPLICATION, IF NECESSARY) IS ATTACHED AND CONTAINS THE BELOW INFORMATION, COMPLETION OF PART I OF THIS FORM IS OPTIONAL.

EMPLOYEE/SUBSCRIBER NAME:_____ ID#: _____

EMPLOYEE/SUBSCRIBER ADDRESS: _____

_____

GROUP NAME: _____ GROUP NUMBER: _____

ADD: (EXISTING FAMILY POLICIES ONLY)

LAST NAME (IF DIFF.)	FIRST NAME	DATE OF BIRTH MO	DAY	YR	RELATIONSHIP SON	DAU	IF STUDENT, NAME OF SCHOOL	# CREDIT HOURS	GRAD DATE	IS MEMBER DISABLED?	CHECK BOXES IF MEMBER HAS MEDICARE
											FEDERAL MEDICARE CLAIM NUMBER_____ [ ] PART A EFF. DATE_____ [ ] PART B EFF. DATE_____

NAME AND ADDRESS OF PERSON OR AGENCY ASSIGNED RIGHT OF PAYMENT OF BENEFITS UNDER MEDICAL CHILD SUPPORT ORDER FOR THE CHILD(REN) NAMED ABOVE:*

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ CHILD'S ADDRESS IF DIFFERENT: _____

_____ _____

_____ _____

**If coverage is being provided through a noncustodial parent/subscriber, information will be provided to the custodial parent (or other designated representative) to enable the child(ren) to obtain benefits, and the custodial parent, designated representative or approved health care provider may directly submit claims for covered services. Any required employee contributions necessary to provide coverage for the above-named child(ren) will be withheld from the employee's income.*

SIGNATURE OF EMPLOYEE_____ DATE _____/_____/_____

PART II: TO BE COMPLETED BY PLAN ADMINISTRATOR FOR GROUP (REQUIRED)

I have reviewed the attached medical child support order and certify that it meets the definition of a "Qualified Medical Child Support Order" as defined in Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") or Section 1908 of Title XIX of the Social Security Act. The above-named child(ren) is/are eligible for coverage under our employee's contract. Please add the child(ren) to our group on the effective date of _____. If the medical child support order is a National Medical Support Notice, I certify that is has been "appropriately completed" and meets the requirements of Sections 609(a)(3) and (a)(4) of ERISA.

I understand that, unless the Qualified Medical Child Support Order specifically directs otherwise, coverage for the above-named child(ren) will continue for the maximum period provided in the contract, unless Excellus Health Plan, Inc. is provided satisfactory written evidence that either the Qualified Medical Child Support Order is no longer in effect, the child is or will be enrolled in comparable health coverage through another insurer (which will take effect no later than the effective date of such cessation of coverage), or the employer has eliminated health coverage for all similarly situated employees. I further understand that, as the plan administrator, I shall not allow the cancellation of coverage for this/these child(ren) under our employee's contract unless it is lawful to do so.

_____ **DATE _____/_____/_____**

SIGNATURE OF PLAN ADMINISTRATOR

_____

PRINT NAME