North Carolina
State Health Plan

CERTIFICATION OF DEPENDENT ELIGIBILITY

To Be Completed By Plan Member:

PLAN MEMBER'S NAME	ID NO.
ADDRESS	
CHILD'S NAME	DATE OF BIRTH (MONTH, DAY, YEAR)

☐ This is my natural child.

☐ This is my stepchild since: _____ .

☐ This is my legally adopted child.

☐ This is my foster child who is unmarried, under 19 years old and living in a relationship having all the characteristics of a parent-child relationship other than being the natural child and it is expected that I shall continue to rear the child to adulthood. **(Please submit written documentation or other evidence of a bona fide foster child relationship setting forth all relevant aspects of the relationship.)**

I hereby certify that all the information given above is true and complete, and I recognize that the claims processing contractor shall rely upon this information as a material inducement for the coverage of said child under the certificate issued to the undersigned. I understand that a false statement or false representation of fact will result in the termination of my coverage.

_____ _____

Signature of Plan Member Date Signed

YOU WILL BE NOTIFIED IF YOUR DEPENDENT IS NOT ELIGIBLE.