

Legal Guardianship Notification & Dependency Verification

CO-1318 New 5/2012



EMPLOYEES: FORWARD TO YOUR AGENCY PAYROLL/HUMAN RESOURCES OFFICE
RETIREEES: RETURN TO RETIREMENT HEALTH UNIT, HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

EMPLOYEE/RETIREE NAME (Last Name, First Name, MI)		EMPLOYEE NUMBER	DATE OF BIRTH
HOME ADDRESS		PERSONAL E-MAIL ADDRESS	
HOME/CELL PHONE NUMBER () -		EMPLOYING AGENCY NAME/ADDRESS	
CHILD'S NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	CHILD'S SSN# XXX-XX-

I have been named as the legal guardian of the child identified above. The child is under the age of 18 and is enrolled as a dependent on my state-sponsored health coverage. In accordance with recently clarified dependent eligibility rules, I request that this child be classified as my ward.

Provide a separate form for each child.

I (or my spouse) am the above-identified child's legal guardian.

A copy of the legal guardianship order is attached. The legal guardianship ends on ____/____/____ or no stated date.

The child should be classified as my (male/female) Ward.

The child should be classified as my (male/female) Temporary Ward. (Only use if guardianship order has stated expiration date)

EMPLOYEE SIGNATURE	DATE
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THIS SECTION TO BE COMPLETED BY AUTHORIZED AGENCY PERSONNEL

Is this employee currently enrolled in or eligible for a state-sponsored Medical Plan? YES NO

Preparer's Name	Preparer's Signature
Date	Preparer's E-Mail