CAMBRIDGE PUBLIC EMPLOYEES
DENTAL & VISION FUND

DEPENDENT CHILDREN ENROLLMENT APPLICATION (AGE 19 – UNDER 26)

You may apply to re-enroll any of your dependent children who were removed and now meet the new eligibility requirements. Please complete all sections of this form for the dependent children you would like to re-enroll under your dental and vision coverage.

Important Information:

1. Send completed Form to:

Cambridge Public Employees Dental and Vision Fund
125 CambridgePark Drive, Suite 104
Cambridge, MA 02140

Email: info@cdvfund.org

SECTION A: MEMBER INFORMATION (EMPLOYEE) **PRINT CLEARLY**

LAST NAME:	FIRST NAME:	M.I.

SSN:	DOB (MM/DD/YYYY):	HOME PHONE:	OTHER PHONE:

HOME ADDRESS:

CITY:	STATE:	ZIP CODE:

EMAIL ADDRESS (IF YOU HAVE ONE):

SECTION B: DEPENDENT CHILD INFORMATION **PRINT CLEARLY**

LAST NAME:	FIRST NAME:	M.I.

DOB (MM/DD/YYYY)	SEX: M / F	HOME PHONE:	OTHER PHONE:

- **Will this dependent be under the age of 26 on July 1, 2021?** ☐ **YES** ☐ **NO**
- **Is this dependent unmarried?** ☐ **YES** ☐ **NO**
- **Is this dependent financially dependent on you for support & claimed on your taxes?** ☐ **YES** ☐ **NO**
- **Is the dependent enrolled in dental coverage under any other plan?** ☐ **YES** ☐ **NO**

If yes, please indicate:

Coverage through: ☐ **Employer** ☐ **Member's Spouse** ☐ **Dependent's Spouse**

☐ **Medical Assistance** ☐ **Other:**_____

Coverage Effective Date: _____

Note: If the dependent child is <u>not a claimed dependent that is financially dependent on you or has coverage under another plan, then the dependent child is not eligible to re-enroll</u> under the member(s) dental and vision coverage.

SECTION C: MEMBER SIGNATURE

Please sign, date, and return this completed form to the Cambridge Public Employees Dental & Vision Fund Office.

By signing this form, I am acknowledging that I am applying for re-enrollment into the Cambridge Public Employees Dental and Vision Fund Coverage for my dependent child listed above. The information I have provided is accurate and complete to the best of my knowledge. I understand that I must notify the Fund Office as soon as possible of the occurrence of an event that affects the eligibility of me or any person covered under the Plan through me to receive benefits under the Plan or the eligibility of such person to have coverage under the Plan.

SIGNATURE:	DATE: