



**NEW WEST
HEALTH SERVICES**

Dependent Re-enrollment Form For Employer-Sponsored Coverage

Complete and submit this form by May 21, 2010 to re-enroll a dependent under age 26 who previously lost coverage. The effective date of coverage will be **May 1, 2010**.

Please print:

Employee's name

New West Member ID

Dependent's full name (First, Last)

Dependent's date of birth

Dependent's mailing address (if different from policyholder):

Street or P.O. Box

City

ST

Zip

This section to be completed by the employee:

- My dependent child's coverage was terminated:
- Due to reaching age 25, on or after September 23, 2009; or
 - Due to marriage.

I wish to re-enroll this dependent effective **May 1, 2010**.

- ➔ **NOTE:** The re-enrollment of this dependent may result in additional premium, depending on your employer's contribution and/or the number of dependents already enrolled on your coverage. Ask your employer whether you will be responsible for any additional premium.

I understand that coverage for the above dependent may remain in effect through the month in which he or she turns 26. I also understand that a married dependent's spouse and/or children are not eligible to enroll.

- I certify that my dependent child is not eligible for any other employer-sponsored coverage.

Employee Signature

Date

◆ Return this completed form by May 21, 2010 ◆

New West Health Services, PO Box 548, Kalispell MT 59903