Strictly Confidential

FORM 1A - DEPENDENT CONFIRMATION FORM

If requested, please complete this form in its entirety and email to DepAudit@HRBestPractices.com or fax to 1 (855) 259-6088. This form is used to continue benefits for eligible dependents, OR to remove a member(s) from the medical plan.

Employee Acknowledgement

- Below, I have identified dependents that:
  a) Meet the eligibility criteria for ACME's medical plan as described in the plan documents and summarized in the enclosed **Dependent Eligibility Reference Guidelines**, and/or,
  b) Need to be removed from ACME's medical plan.
- I understand that ineligible dependents that have been removed from ACME's medical plan coverage may be eligible for COBRA continuation coverage ***ONLY*** if a qualifying event has occurred within the last 60 days.
- I also understand that removal of an ineligible dependent that was never eligible is not considered a qualifying event, and therefore the removal of this individual from ACME's medical plan does not qualify for COBRA continuation coverage.

Instructions: Please complete the form below for each of your dependents currently covered under ACME's medical plan. Please add separate pages as needed.

Dependent Name	Relationship	Confirm ("Yes" to confirm or "No" to remove)	Removal Reason
Example: Jane Doe	Child	No	Over the age of 26

I acknowledge that the above dependent information provided on this **DEPENDENT CONFIRMATION FORM** and the information provided on the **WORKING SPOUSE TELEPHONE SURVEY** is true and may be used to validate enrollment of these dependents in the ACME Medical Plan. ***Any false information provided by any employee will be considered grounds for disciplinary action up to and including termination of employment as well as back payment of actual healthcare claims or insurance premiums.***

Employee Name_____ Date_____

Employee Signature_____ Survey Code:

Phone Number (Print Clearly) _____ Email_____