EASTERN
MICHIGAN UNIVERSITY

2017 DENTAL VERIFICATION FORM
FOR DEPENDENT CHILDREN AGES 19-24

_____ E_____

Employee name (Print) Employee ID

Employee Classification:

☐ AC ☐ AH ☐ AP ☐ CA ☐ CP ☐ CS ☐ FA ☐ FM ☐ LE ☐ PE ☐ PS ☐ PT ☐ VF

Please indicate your intent to continue dental coverage for your dependent children below. There is no cost for the dental coverage for your dependent children through the **end of the year they turn 25, provided they are an IRS dependent, as defined by the U.S. Internal Revenue Code, and will be claimed on your 2017 Federal Income Tax Return.** (Sponsored dependents are not eligible for dental coverage.)

Please complete appropriate columns below.

Dependent Child Name	Birth Date	Continue Dental Coverage	Discontinue Dental Coverage	Reason	
				Other Coverage	Ineligible

_____ _____

Employee Signature Date

Please return this form to the Benefits Office by October 31, 2016 before 4:00 p.m.

Failure to return this form will result in cancelation of your dependent's coverage.

If you have any questions, please call (734) 487-3195 or email hr_benefits@emich.edu.