



Intent to Claim Dependents

I, «First Name»«Last Name», hereby state the dependent(s) listed below

Reside in my home

Do not reside in my home

and are eligible to be claimed as my dependent(s) on my Federal Income Taxes, Form 1040. I understand it is my responsibility to remove the dependent(s) when they no longer live with me and/or are not eligible to be claimed as my tax exemption.

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: A Social Security Number is required for any dependent(s) being added to your health care coverage. If it has not yet been provided, it must be obtained and reported to the Company within six (6) months from the effective date of coverage or the dependent will be removed from your coverage.

Call the NESC at 1-800-248-4444 and provide the social security number when you receive it.

I understand and agree to repay promptly all monies for claims or premiums incurred for any ineligible person(s) I enroll, and for services my dependent(s) or I were not entitled to, as determined by the Company. If I fail to repay such monies promptly after the Company has mailed a written notice to my last known address stating that such monies are owed and payable, I authorize the Company to make an appropriate deduction or deductions for recovering such overpayments from any present or future compensation payable by the Company until such monies are fully repaid.

I declare the above information to be true, and accurate, to the best of my knowledge.

Employee Signature

State of Residence: _____

Date

Last 4 digits of employee's Social Security Number

All areas of the form must be completed and the form must be signed before the above listed individual(s) can be added to your coverage.