

FAMILY ENROLLMENT CHANGES

(FPM 890)

DATE

EMPLOYEE'S
NAMEENROLLMENT
CODE**SPOUSE****(FOR ADDING OR DELETING SPOUSE)**

NOTE - A CERTIFICATE OF COMMON LAW MARRIAGE IS REQUIRED IN ORDER TO OBTAIN COVERAGE FOR A SPOUSE DUE TO COMMON LAW MARRIAGE.

NAME OF SPOUSE

BIRTH DATE

DATE OF MARRIAGE

NAME OF FORMER SPOUSE

BIRTH DATE

DATE OF DIVORCE

DATE OF DEATH

DEPENDENT CHILDREN**(FOR ADDING OR DELETING DEPENDENT CHILDREN)** (COMPLETE THE FOLLOWING ON ALL DEPENDENT CHILDREN UNDER AGE 22)

NOTE - DEPENDENT CHILDREN BECOME INELIGIBLE FOR COVERAGE AT AGE 22 OR MARRIAGE, WHICHEVER OCCURS FIRST, UNLESS INCAPABLE OF SELF-SUPPORT BECAUSE OF MENTAL OR PHYSICAL INCAPACITY WHICH EXISTED BEFORE AGE 22. (PROOF OF INCAPACITY MUST HAVE BEEN SUBMITTED TO CIVILIAN PERSONNEL OFFICE, TECHNICAL SERVICES BRANCH)

ADD THE FOLLOWING CHILDREN TO MY POLICY

| LAST NAME | FIRST NAME | BIRTHDATE | RELATIONSHIP | DATE ELIGIBLE FOR COVERAGE |
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DELETE THE FOLLOWING CHILDREN FROM MY POLICY

| LAST NAME | FIRST NAME | BIRTHDATE | RELATIONSHIP | REASON FOR DELETION |
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EMPLOYEE CERTIFICATION

I CERTIFY THAT ANY STEP CHILDREN OR FOSTER CHILDREN INCLUDED ABOVE LIVE WITH ME IN A REGULAR PARENT-CHILD RELATIONSHIP. I AM REARING THE CHILD AS MY OWN AND EXPECT TO CONTINUE TO REAR THE CHILD INTO ADULTHOOD. THE NATURAL PARENT IS NOT LIVING WITH OR EXPECTED TO LIVE WITH THE FOSTER PARENT UNTIL THE CHILD REACHES ADULTHOOD.

EMPLOYEE'S SIGNATURE_____
DATE**DCP CERTIFICATION**

THE ABOVE LISTED DEPENDENT CHILD/CHILDREN ARE ELIGIBLE FOR COVERAGE UNDER EMPLOYEE'S HEALTH BENEFIT PLAN BASED ON PROOF FURNISHED AND/OR DISCUSSION WITH EMPLOYEE.

DCP REPRESENTATIVE'S SIGNATURE_____
DATE