

# Enrolling an Eligible Grandchild

## A Your Personal Information

Name (First)	MI	Last	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			Member ID
Address	(      )		(      )
			Home Phone      Work Phone
City	State	ZIP Code	County

## B Your Grandchild's Information

Grandchild's Name (First)	MI	Last	-      - Social Security Number
Effective Date of Grandchild's Coverage (MM/DD/YYYY)	<input type="checkbox"/> F <input type="checkbox"/> M Grandchild's Gender		Birth Date (MM/DD/YYYY)

## C Eligibility Criteria Information

Your grandchild is eligible for coverage under the ELCA Health Benefits Plan if she or he meets the eligibility criteria. (Visit [PorticoBenefits.org](http://PorticoBenefits.org) or see eligibility information in the *Summary Plan Description for the ELCA Health Benefits Plan*.)

1. Is this individual your grandchild?  Yes     No
2. Is this grandchild living in your home?  Yes     No
3. Is this grandchild receiving primary support from you?  Yes     No  
 If yes, what date did you assume primary support for this grandchild? (MM/DD/YYYY) \_\_\_\_\_
4. Is this grandchild eligible to be claimed as your dependent for federal income tax purposes?  Yes     No
5. Is this grandchild covered under other employer-provided group health coverage?  Yes     No  
 If yes, what what is the name of the other health coverage: \_\_\_\_\_

**D Signature of Member**

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I certify the information provided on this form is true and complete to the best of my knowledge. I understand this form must be returned **within 60 days** of my grandchild's eligibility or she or he will have a 90-day waiting period for health coverage. The only exceptions to this are through special enrollment (if she or he had other employer-provided group health coverage within the 60 days prior to enrollment in the ELCA health plan) or annual open enrollment.

Signature of Member (**Required**)

Date (MM/DD/YYYY)

**E Signature of Sponsoring Employer**

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We agree to enroll this eligible grandchild in the ELCA Health Benefits Plan.

Signature of Sponsoring Employer (**Required**)

Date (MM/DD/YYYY)

**Return this completed form to the Portico Service Center.**

Portico Benefit Services  
800 Marquette Ave., Ste. 1050  
Minneapolis, MN 55402-2892

800.352.2876 / 612.333.7651

F 612.334.5399

*mail@PorticoBenefits.org*

*PorticoBenefits.org*

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