Date: [Insert Date]

To: [Employee Name]

Employee ID: [Insert ID]

Subject: Action Required: Dependent Coverage Eligibility Update

Dear [Employee Name],

Our records indicate that your dependent, [Dependent Name], will soon reach the maximum age limit for coverage under our group benefit plans on [Date of Birthday]. This is considered a qualifying Life Event.

To ensure your benefit elections are adjusted correctly, please complete the following questionnaire and return it to the Human Resources department by [Deadline Date].

Dependent Eligibility Questionnaire

1. Will your dependent remain a full-time student after their [Age] birthday?
( ) Yes
( ) No

2. Does your dependent meet the criteria for "Disabled Dependent" status as defined by the plan provider?
( ) Yes
( ) No

3. Do you wish to remove this dependent from the following plans? (Check all that apply)
[ ] Medical
[ ] Dental
[ ] Vision
[ ] Dependent Life Insurance

4. Would you like to receive information regarding COBRA continuation coverage for your dependent?
( ) Yes
( ) No

Employee Certification:

I certify that the information provided above is true and accurate. I understand that misrepresentation of dependent status may result in the loss of coverage or disciplinary action.

Signature: _____ Date: _____

Please return this form to [HR Department Email/Address]. Failure to respond by [Deadline Date] may result in the automatic termination of coverage for this dependent.

Sincerely,

The Benefits Administration Team
[Company Name]