Legal Guardianship Notification & Dependency Verification

CO-1318 New 1/2023

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
165 Capitol Ave.
Hartford, CT 06106-1775
www.osc.ct.gov

EMPLOYEES: FORWARD TO YOUR AGENCY PAYROLL/HUMAN RESOURCES OFFICE
RETIREES: RETURN TO RETIREMENT HEALTH UNIT, HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

EMPLOYEE/RETIREE NAME (Last Name, First Name, MI)	**EMPLOYEE NUMBER**	**DATE OF BIRTH**

HOME ADDRESS	**PERSONAL E-MAIL ADDRESS**
HOME/CELL PHONE NUMBER **( ) -**	**EMPLOYING AGENCY NAME/ADDRESS**

CHILD'S NAME	**DATE OF BIRTH**	**GENDER**	**CHILD'S SSN#** **XXX-XX-**

I have been named as the legal guardian of the child identified above. The child is under the age of 18 and is enrolled as a dependent on my state-sponsored health coverage. In accordance with recently clarified dependent eligibility rules, I request that this child be classified as my ward.

Provide a separate form for each child.

☐ I (or my spouse) am the above-identified child's legal guardian.

☐ A copy of the legal guardianship order is attached. The legal guardianship ends on _____/_____/_____ or no stated date.

☐ The child should be classified as my (male/female) Ward.

☐ The child should be classified as my (male/female) Temporary Ward. (Only use if guardianship order has stated expiration date)

EMPLOYEE SIGNATURE	**DATE**

THIS SECTION TO BE COMPLETED BY AUTHORIZED AGENCY PERSONNEL

Is this employee currently enrolled in or eligible for a state-sponsored Medical Plan? ☐ **YES** ☐ **NO**

Preparer's Name	**Preparer's Signature**
Date	**Preparer's E-Mail**