

## Dependent Verification Form

<b>Subscriber's Name</b>	
<b>BIN or SSN</b>	
<b>Employer Name</b>	
<b>(Optional) Group Number</b>	

Please submit this form with the appropriate documentation for each of your covered dependents. Attach the documents to this form using a staple or paper clip.

Dependent Name	Verification Enclosed
	<input type="checkbox"/>

I have enclosed the appropriate documentation for each of my covered dependents as indicated above. I understand that any dependent not verified will be considered ineligible for coverage under EIP and removed from my coverage. I further understand that ineligible dependents removed as a result of this audit cannot re-enroll as my dependent in any EIP coverage.

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date

Return by mail to:

Employee Insurance Program  
PO Box 11661  
Columbia, SC 29211-9858