



A spirit of innovation, a legacy of care.

Catholic Health Initiatives Health Plans Dependent Audit Form

Statement Date 07-29-2009

JANE M. SAMPLE
123 MAIN STREET
CITY STATE ZIP

What You Need to Do by **08-25-2009**

1. Review and gather the required documentation listed on the Dependent Audit Notice. Make copies and black out Social Security numbers, account numbers and financial data.
2. Sign and date this form.
3. Fax your documents, with this form on top, to 1-866-411-2906.

Tips for Faxing

- Do not include a separate cover sheet—this notice is your cover sheet.
- Ensure this form and your documents are legible.
- Do not strike through the bar code on this form.

Postal Mail

If you would rather make copies of your documents and mail them with this form, send the information to: HR/Payroll Connection, 100 Half Day Road, Lincolnshire, IL 60069-9999. Do **not** mail original documents because they will be destroyed.

Covered Dependent(s) Requiring Documentation

Name	Birth Date	Relationship	Full-Time Student Age 19 to 25	Coverage	Status
John M. Sample	[MM-DD-CCYY]	Spouse	—	Medical Dental Vision	Need Documentation
Susan J. Sample	[MM-DD-CCYY]	Child	—	Medical Dental	Need Documentation
Thomas J. Sample	[MM-DD-CCYY]	Child	Yes	Medical Dental	Need Documentation
Mary A. Sample	[MM-DD-CCYY]	Child	No	Medical Dental	Need Documentation



Signature

I certify that the information provided about my dependent's eligibility for Catholic Health Initiatives' plans is true and correct.

Signature

Date