I, ____________________________ do hereby attest that the following is/are my
stepchild(ren):

<table>
<thead>
<tr>
<th>Print stepchild name</th>
<th>Print stepchild name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print stepchild name</td>
<td>Print stepchild name</td>
</tr>
<tr>
<td>Print stepchild name</td>
<td>Print stepchild name</td>
</tr>
</tbody>
</table>

The above named stepchild(ren):  (check one box below)

☐ is/are not covered under another health plan.

☐ is/are covered under another health plan. (Complete section below.)

Other Health Plan Name

Other Health Plan ID/Group #

Name of Policy Holder for Other Health Plan

_____________________________  ______________________________
Members signature                                Date

Member ID#:

***You may fax this completed form to (610)325-9028 or mail to the address above***

ANY PERSON WHO FILES THIS FORM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND WILL BE RESPONSIBLE FOR REIMBURSING THE NEI HEALTH BENEFIT PLAN FOR CLAIMS THAT THE NEI HEALTH BENEFIT PLAN SHOULD NOT HAVE PAID FOR.