

**THE UNIVERSITY OF TEXAS-HOUSTON
HEALTH SCIENCE CENTER**

Certificate of Group Health Plan Coverage

In order to add my dependent(s) to UTHHSC group medical insurance, I understand evidence of insurability is not required if they are currently covered under another group plan.

EMPLOYEE NAME: _____ **Empl ID:** _____

My dependent(s) are currently covered under the group health plan at:

Employer: _____ Coverage begin date: _____

Coverage end date: _____

Dependents to be added:

NAME	SSN	BIRTHDATE	RELATIONSHIP

EMPLOYEE'S SIGNATURE

DATE