Dependent Eligibility Verification Form

Employee Name: [Employee First Name Last name]
Employee Address: [Street Address]
[City, State Zip]
Company Name: Vertiv

Please complete this form of dependents (spouse and children) currently enrolled in your Vertiv health plan. If a dependent is no longer eligible, please put an X next to their name. You will need to provide the required documents to the Center for Benefits Management for each eligible dependent no later than **XXXXX** in order to continue their health coverage.

Dependent Name	Relationship	Last 4 digits of SSN
Dependent 1	Spouse or child	1234
Dependent 2	Spouse or child	2345
Dependent 3	Spouse or child	3456

CERTIFICATION:
This form must be signed by the Employee and returned with the required documents.

I certify that the information provided above is complete and accurate. I verify that the individuals listed on this form are indeed my dependents. I understand that if I have knowingly provided false and/or misleading information, Vertiv Company can take disciplinary action (up to and including benefit cancellation or employment termination).

Employee Signature	**Date**	**Phone Number**