January 22, 2018

**REMOVE ADULT DEPENDENT FROM HEALTHCARE PLANS**

I certify that the dependent named below, is under the age of 26 and **does have** access to health care coverage. I give FirstEnergy permission to remove this adult dependent from my health care coverage(s) as indicated below.

**EMPLOYEE/RETIREE INFORMATION**

Name ______________________________ SAP # ______________

Union (if applicable) ______________________________

**ADULT CHILD'S INFORMATION**

Name ______________________________ Date of Birth ______________

SSN ______________________________ Sex ❑ Male ❑ Female

**Please remove my adult child from my FirstEnergy health care coverage checked below.** Your dependent will be removed:

***1st day of the following month from the date completed form is received by the HRSC***

❑ Medical/Rx ❑ Dental ❑ Supplemental Vision

I certify that the above-named is my adult dependent, and is under the age of 26 and **does have** access to health care coverage. I give FirstEnergy permission to remove this adult child from my health care coverage(s) as indicated above.

Signature: ______________________________ Date: ______________________

***You will receive a Benefits Confirmation*** *at your home address once your benefit forms have been processed. If you have any questions, please do not hesitate to contact the HR Service Center at 1-800-543-4654.*

**Please return completed form to the appropriate location below.**

If you **work in OH** return to this location:

Attn: HRSC A-GO-7
FirstEnergy Corp
76 South Main Street
Akron OH 44398
or
**Interoffice Mail:** HRSC, A-GO-7
**Fax #:** 330-761-2314

If you **do not work in OH** return to this location:

Attn: HRSC R-REAP-51
FirstEnergy Corp
2800 Pottsville Pike
P O Box 16001
Reading PA 19612
or
**Interoffice Mail:** HRSC, R-REAP-51
**Fax #:** 330-315-9220