

Dependent Child Affidavit

Employment Information		
Date Affidavit Received (For employer use):	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	Union Group: _____ <input type="checkbox"/> Check here if you are/were Non-Union.
Employee/Retiree Information		
Name:		Social Security No:
Current Address:		Home Phone:
City, State, Zip		Other Contact Phone:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Number of dependents listed on your insurance: _____
Child Verification - Please complete one form for each child enrolled in the health plan. Make additional copies of this form as needed.		
Your Child's Name:		Social Security No:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Is your child married? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship: <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> You or your spouse are required to provide coverage under the terms of a court decree.		
If your child is 19-25 years of age, is he/she a full-time college student? <input type="checkbox"/> Yes <input type="checkbox"/> No *Proof of educational enrollment is required. Transcripts or a letter from the college confirming attendance between Sept 2008 through May 2009 are acceptable forms of proof.	Is your child covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Mark this box if your child was over 19 as of last December 31st, and your child is totally and permanently disabled. Note: A disabled child may continue to be covered by the plan until the disability ends. However, a licensed physician must determine the child is totally and permanently disabled prior to the child's 19th birthday for coverage to continue.		
Your Child's Name:		Social Security No:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Is your child married? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship: <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> You or your spouse are required to provide coverage under the terms of a court decree.		
If your child is 19-25 years of age, is he/she a full-time college student? <input type="checkbox"/> Yes <input type="checkbox"/> No *Proof of educational enrollment is required. Transcripts or a letter from the college confirming attendance between Sept 2008 through May 2009 are acceptable forms of proof.	Is your child covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Mark this box if your child was over 19 as of last December 31st, and your child is totally and permanently disabled. Note: A disabled child may continue to be covered by the plan until the disability ends. However, a licensed physician must determine the child is totally and permanently disabled prior to the child's 19th birthday for coverage to continue.		

To list more children, use the other side of this form. Make additional copies of this form as needed.

Please remember to sign the bottom of the form on the other side of this document.

Dependent Child Affidavit

Your Child's Name:		Social Security No:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Is your child married? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship: <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> You or your spouse are required to provide coverage under the terms of a court decree.		
If your child is 19-25 years of age, is he/she a full-time college student? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Proof of educational enrollment is required. Transcripts or a letter from the college confirming attendance between Sept 2008 through May 2009 are acceptable forms of proof.</small>		Is your child covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mark this box if your child was over 19 as of last December 31st, and your child is totally and permanently disabled. Note: A disabled child may continue to be covered by the plan until the disability ends. However, a licensed physician must determine the child is totally and permanently disabled prior to the child's 19th birthday for coverage to continue.		
Your Child's Name:		Social Security No:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Is your child married? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship: <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> You or your spouse are required to provide coverage under the terms of a court decree.		
If your child is 19-25 years of age, is he/she a full-time college student? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Proof of educational enrollment is required. Transcripts or a letter from the college confirming attendance between Sept 2008 through May 2009 are acceptable forms of proof.</small>		Is your child covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mark this box if your child was over 19 as of last December 31st, and your child is totally and permanently disabled. Note: A disabled child may continue to be covered by the plan until the disability ends. However, a licensed physician must determine the child is totally and permanently disabled prior to the child's 19th birthday for coverage to continue.		
The most common method of proving eligibility is to provide the following documents:		
Natural Children:	<input checked="" type="checkbox"/> A copy of the birth certificate and <input checked="" type="checkbox"/> A copy of your most recent federal or state tax return. (Let Benefits & Risk Management know if your child is eligible for coverage, but you did not claim them as a dependent on your tax return. You may provide other documents that prove your child's eligibility.)	
Step Children:	<input checked="" type="checkbox"/> A copy of the birth certificate and <input checked="" type="checkbox"/> A copy of your marriage certificate and/or <input checked="" type="checkbox"/> A copy of your most recent federal or state tax return.	
Adopted children and children for whom you have legal guardianship.	<input checked="" type="checkbox"/> A copy of a legal document of adoption or guardianship and <input checked="" type="checkbox"/> A copy of your most recent federal or state tax return.	
Children for whom you or your spouse are required to provide coverage by court decree.	<input checked="" type="checkbox"/> A copy of the court decree	
Employee Signature:		
I certify that the information on this form is true. If it is determined later that I provided false information, I understand that I may be held responsible for ineligible claims paid by the plan.		
Signed:		Date: