 Affidavit of Dependency Form

 Certification of Child Dependency for LCC Medical Insurance

# Employee Information

**Employee Name:** Click here to enter text.

**Employee Banner ID:** Click here to enter text.

# Dependent Information

**Dependent Name:** Click here to enter text.

**Dependent Birth Date:** Click here to enter text.

**Calendar Year of Benefit Eligibility:** Choose an item.

## Eligibility

In order to maintain eligibility for medical insurance past the month of their 26th birthday, a child must meet the following requirements: (1) was covered under this program at the end of the month of their 26th birthday, (2) is a full-time student\*, (3) is unmarried, (4) lives primarily with you (unless temporarily away at school), and (5) you provide over 50% support **OR** (1) was covered under this program at the end of the month of their 26th birthday, (2) before age 19, is mentally or physically disabled, (3) is dependent upon you for a majority of their support, and (4) is incapable of self-sustaining employment by reason of their mental or physical disability

\*A “Full-time Student” is someone who enrolls during each of at least five months during the taxable year for what is considered a full-time course of study at an ongoing educational organization.

# Acknowledgement

I certify that the above dependent fully meets the definition of eligibility listed above.

I agree to notify my employer if there is any change in the dependency status that would make this dependent no longer eligible for benefits within 30 days of any change.

I certify under penalty of perjury that all the information contained in this Affidavit is true and correct. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

## Signature

**Employee Signature:**  **Date:**