Brevard Public Schools
Dependent Age 26-30 (Non - Disabled) Affidavit

Effective date of change: ________________ Site # ________________

Medical, Dental, Vision, AD&D, Dependent Life

Employee Last Name:	First Name:	Employee ID#:
Dependent's Name:		Dependent's Date of Birth:

1. Is this dependent your child?

☐ Yes ☐ No

2. Is this dependent married?

☐ Yes ☐ No

3. Does this dependent have children of his/her own?

☐ Yes ☐ No

4. Does this dependent live in the State of Florida?

☐ Yes ☐ No

5. If you answered "No" to question 4 above, is this dependent a full-time or part-time student?

☐ Yes ☐ No

6. a. Does this dependent have other **Medical** coverage, or is medical insurance offered through his/her employer?

☐ Yes ☐ No

b. If you answered "No" to 6.a. above, do you wish to enroll this dependent for **Medical**?

☐ Yes ☐ No

> If Yes, a supplemental cost is assessed to cover this dependent

7. Do you wish to enroll this dependent for dental? [If yes, this benefit will become *post*-tax]

Dental

☐ Yes ☐ No

8. Do you wish to enroll this dependent for vision? [If yes, this benefit will become *post*-tax]

Vision

☐ Yes ☐ No

9. a. Is this dependent provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise *health* insurance policy or individual *health* benefit?

☐ Yes ☐ No

b. If you answered "No" to 9.a. above, do you wish to enroll this dependent for **AD&D** coverage?

☐ Yes ☐ No

c. If you answered "No" to 9.a. above, do you wish to enroll this dependent for **Life** coverage?

☐ Yes ☐ No

I certify that the information provided on this form is a true and correct representation. I understand that a deliberate misrepresentation of the facts on this affidavit may result in the termination of this dependent's medical coverage.

Employee Signature: ____ Date: ________________________

Return this document to Employee Benefits with your benefit change form. <u>If we do not receive this document, your dependent will not be covered</u>.

Florida Statute 817.234 - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree