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:	Eiro	t Name:	Employee ID#:
Employee Last Name.	FIIS	i Name.	Employee ID#:
Dependent's Name:		Dependent's D	eate 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	s/her o	wn?	
Yes	П	No	
4. Does this dependent live in the State of F	Florida	?	
Yes	П	No	
5. If you answered "No" to question 4 above	o io thi		art time student?
<u>·</u>	ا ان در	·	art-time student:
Yes		No	
6. a. Does this dependent have other Medi	cal cov	_	nce offered through his/her employer?
Yes	Ш	No	
b. If you answered "No" to 6.a. above, do	you v	vish to enroll this dependent	for Medical?
Yes > If Yes, a supplemental cost is a		No red to cover this dependen	t
7. Do you wish to enroll this dependent for dental? [If yes, this benefit will become <i>post</i> -tax]			
Dental	ucintai	: [ii yes, this beliefit will be	come post tax
Yes		No	
8. Do you wish to enroll this dependent for	vision?	[If yes, this benefit will bec	ome post-tax]
Vision	_		
Yes		No	
9. a. Is this dependent provided coverage a			
other group, blanket, or franchise <i>hea</i> . Yes	ith ins	urance policy or individual <i>n</i> e No	ealth benefit?
	اسا		for ADOD coverage?
b. If you answered "No" to 9.a. above, do	o you v	No	Tor AD&D coverage?
	لــا		for Life coverage?
c. If you answered "No" to 9.a. above, do		No	Tor Life coverage?
I certify that the information provided on this form of the facts on this affidavit may result in the tern			
Facility of Charles			Date
Employee Signature:			Date:
Return this document to Employee Benefits with you	ur benef	it change form. <u>If we do not receive</u>	this document, your dependent will not be covered.
Florida Statute 817.234 - Any person who knowingly application containing any false, incomplete, or mislea			

H:Forms/Dependent Affidavit 26-30 revised 11/6/2017