

# JPOFFHIT Overage Dependent Affidavit

## Employee Information

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

## Dependent Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

A dependent child can remain on your medical plan from the age of 26 up to the end of the month in which they turn 30 years old if he or she meets the following criteria:

- Is unmarried,
- Has no dependents of his or her own,
- Is dependent on the employee for financial support,
- Is not offered coverage through another group or individual plan,
- Is not entitled to benefits under Title XVIII of Social Security Act, and
- Is either a resident of Florida or a full-time or part-time student living out of the state of Florida.

You are required to complete an affidavit within 30 days of your dependent turning 26. You will then be required to resubmit an affidavit every year during open enrollment to confirm eligibility for the next plan year. **Failure to complete the affidavit(s) will result in termination of the child's coverage.**

NOTE: Under Florida Statute § 627.6562(3), if a child is provided coverage under your policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under your policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

I solemnly affirm that my covered dependents meet the definition of eligibility. I understand that my employer may request documentation and verification of this information at any time. If any of my dependent information should change in the future, it is my responsibility to notify my employer within 30 days from the date of change.

I understand that I will be taxed on any applicable imputed income from premiums paid on behalf of my overage dependent who is age 26 and above.

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying JPOFFHIT within 30 days from the date of change if there are any changes pertaining to a child's status as my dependent during the plan year. I hereby certify, under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_