

**This form MUST be submitted
for every dependent child
between the ages of 19-25
added to the health plan**



**Kentucky Employees' Health Plan
2013 Certification of Dependent Eligibility**
Must be submitted for covered dependents ages 19 through 25 (up to 26th birthday)

Section I: Statement of Dependency

Name of KEHP Member

Name of Dependent

KEHP Member's Social Security Number

Dependent's Social Security Number

KEHP Member's Phone Number

Dependent's Date of Birth

Section II: Dependent's Status

1. Is this dependent employed? ☐ Yes ☐ No
2. If the dependent is employed, is he/she employed full-time or part-time? ☐ Full-time ☐ Part-time
3. If this dependent is employed full-time, does his/her employer offer group health insurance for which this dependent is eligible? ☐ Yes ☐ No

Name and address of employer: _____

Section III: Acknowledgement

I, the member, and I, the dependent referenced above, do certify under penalty of law that the information I have provided on this affidavit is correct and complete. I understand that omissions or incorrect statements made by me on this affidavit could lead to (1) retroactive loss of benefits for the dependent named above; (2) disciplinary action, up to and including termination of employment; and (3) civil and/or criminal penalties.

I understand that this form is not an application for insurance coverage and that the purpose of this form is to establish eligibility of dependent persons named herein for the coverage provided under the Kentucky Employees' Health Plan.

I understand that this signed affidavit will be retained in my employee benefits file.

Print Name of Member

Print Name of Dependent

Signature of Member

Signature of Dependent

Date

Date

Mail to Kentucky Retirement Systems: 1260 Louisville Rd, Frankfort KY 40601