**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 KEHP:** 501 High Street, 2nd Floor, Frankfort KY 40601