DEPENDENT CHILD CERTIFICATION AFFIDAVIT

Applicable ONLY to MEDICAL Insurance

The Dependent Child Certification Affidavit may **ONLY** be used to verify eligibility of a dependent child 19-26 years of age (child is no longer eligible on the date they attain their 26th birthday), and **MUST** be submitted in addition to a copy of the dependent's child's birth certificate.

In order for this to be a valid document, you must complete, sign, date, and return the Affidavit to the address below. If this Affidavit is not completed and returned with the birth certificate coverage will not be approved. **You must complete a separate Affidavit for each dependent child 19-26 years of age.** (You can make additional copies of this Affidavit if needed.)

Return completed Affidavit, ALONG WITH THE BIRTH CERTIFICATE, to:

Rutherford County Risk Management Department
303 N Church St. Suite 201
Murfreesboro, TN 37130

FAXED AFFIDAVITS ARE NOT ACCEPTABLE

By signing below, I attest that my dependent child(ren) if employed, is not offered employer based healthcare through his/her employer at any time. I understand that knowingly providing false or misleading information on this form may result in disciplinary action up to and including termination of employment. I also understand that if I present false information resulting in the enrollment of ineligible dependents, I am responsible for repaying any claims paid by the plan, and any premium payments made by me will not be refunded. Furthermore, I acknowledge that should my dependent child become eligible for employer based healthcare, I am responsible to notify **in writing** the Rutherford County Risk Management Dept. within thirty (30) days from the date my dependent child becomes eligible.

Dependent Child Information:

Print Name of Child _____

Child's Social Security Number _____

Rutherford County reserves the right to verify that your dependent child is not eligible for employer based coverage. You must complete the information below if applicable.			
Dependent Child's Employer Name:			
Employer Address:			
City:	**State:**	**ZIP Code:**	**Employer Phone No.:** **( )**

Insured Member's Name (PRINT) _____

Insured Member's Signature _____ **Date:** _____

Insured Member's Social Security Number _____