**DEPENDENT CHILD CERTIFICATION AFFIDAVIT**

## Applicable ONLY to DENTAL & VISION Insurance for Dependents 19-25

DEPENDENTS NAME: _____

Under Health Care Reform dependent children up to age 26 may remain covered on an employee's medical benefits. However, Health Care Reform does not pertain to dental and/or vision benefits for children ages 19 up to 25. Our records indicate that the dependent listed below will reach his/her 19th birthday. In order for this dependent child to remain covered on the enrolled dental and/or vision plan, both of the following requirements must be met:

- Is an unmarried dependent child under age 25 and
- Is a student at an educational institution including high schools, colleges, universities, technical schools, mechanical schools and night schools, but only while the dependent child is enrolled for the number of hours or classes that is considered **full-time** attendance at a similar day school. The term educational institution does not include on the job training courses, correspondence courses and other related schools.

If your dependent **does not qualify**, please check the box below.

- My dependent does not qualify to be on the dental and/or vision plan.

By signing below, I attest that my dependent child(ren) listed above is not married and is currently a full- time student. I understand that knowingly providing false or misleading information on this form may result in disciplinary action. 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 have a change in either status stated above, I am responsible to notify in writing the Rutherford County Insurance & Risk Management Dept. within thirty (30) days from the date my dependent child becomes ineligible. For this to be a valid document, you must complete, sign, date, and return the Affidavit to the address below.

**Insured Member's Name (PRINT) _____ Date: _____**

**Insured Member's Signature _____ Last 4 Digits of SS Number: _____**

**Return completed affidavit one of three ways:**

MAIL
Rutherford County Insurance & Risk Management
Attention: Jayne Corbin
303 N. Church Street
Suite 100
Murfreesboro, TN 37130

EMAIL: benefits@rutherfordcountytn.gov

FAX: 615-713-3451, Attention: Jayne Corbin