



## Affidavit of Dependency

School District \_\_\_\_\_ Employee ID, SSN, or E# \_\_\_\_\_

I, (*print name of employee*) \_\_\_\_\_, certify that  
(*print name of dependent*) \_\_\_\_\_ meets the  
dependent eligibility requirements set forth below.

The above named dependent child is not my biological or adopted child; and

- Does not qualify as another person's dependent child, except for a child of divorced or separated parents meeting conditions under Internal Revenue Code Section 152(e) (A) as amended by the Working Families Tax Relief Act of 2004; and
- Pre-OEBC medical insurance coverage was continuous with coverage under OEBC medical insurance; and
- Is single and does not have a domestic partner; and
- The child must be citizen or resident of the United States, Canada or Mexico; and
- Living in the home of the eligible employee over six months of the calendar year, and the eligible employee provides over half the yearly support; or
- Incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

I or my spouse or Domestic Partner, is obligated to support, or contribute to the support of, the above named child.

I understand that it is my responsibility to notify my Educational Entity within 31 days of when the dependent child no longer meets eligibility requirements, by completing and submitting a Change Form. My Educational Entity or insurance carrier may ask, at any time, if the eligibility requirements continue to be met.

I certify that the foregoing is true and accurate to the best of my knowledge.

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