



# Grandchild Affidavit

- Office Use Only -

Approved by \_\_\_ Date\_\_\_

Effective Date \_\_\_\_\_

ONLY use this form to add coverage for a grandchild of an eligible dependent child of you, your spouse's or your domestic partner's. You must certify the grandchild meets one of two eligibility criteria in Section 1. For more information: [www.oregon.gov/DAS/PEBB/SPD.shtml](http://www.oregon.gov/DAS/PEBB/SPD.shtml)

- **Open Enrollment:** You may enroll the child for coverage through the online system; however, the child's enrollment will take effect only if you submit this affidavit and required documentation to your agency within the allowed time.
- **Newly Eligible Employees, Newly Hired Employees, and Active Employees requesting a midyear change:** You must submit enrollment or Midyear Change form, this affidavit, and required documentation to your agency within the allowed time, or the child will not receive coverage.
- **Submit completed affidavit and required documentation to your agency payroll or university benefits office.**
- **Use one affidavit per grandchild.**

<b>1. Contact Information</b>		PEBB Benefit Number (P#####), Employee ID, University ID			
<b>You must complete all fields. (Please Print)</b>					
Last Name		First Name		MI	Agency #
				Gender <input type="checkbox"/> F <input type="checkbox"/> M	
PEBB and the plans in which you enroll will send <b>all</b> benefit-related correspondence to your contact address.					
Contact Address <input type="checkbox"/> Check if New Address		Apt #	City	State	Zip
Residence Zip	Work Zip	Work Email		Personal E-mail (optional)	
Date of Birth (mm/dd/yyyy)		Work Phone		Home Phone (optional)	

<b>2. Certification (you must check one)</b>	
<input type="checkbox"/> I certify that the child is a biological child of a PEBB eligible child and meets the following criteria: <ul style="list-style-type: none"> <li>• <b>The child's parent</b> will not be older than age 26 on December 31, is unmarried, and without a domestic partner.</li> <li>• <b>Both the child and parent</b> live in my household and receive over half of their financial support from me.</li> </ul> Name of biological parent who is your PEBB eligible dependent: _____  Date the grandchild and eligible dependent came to live with you: _____	<input type="checkbox"/> I certify that the child is a biological grandchild or myself, or my spouse/domestic partner and meets the following criteria: <ul style="list-style-type: none"> <li>• <b>The child is younger than 18 and lives in my household</b> and I or my spouse/domestic partner are legally responsible for the welfare of this grandchild.</li> <li>• You must attach legal documentation for guardianship, conservatorship or other legal custody documents.</li> </ul> Date of your legal responsibility: _____  Date legal responsibility ends: _____

## 2. Dependent Grandchild Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

## 3. Employee Signature and Authorization

I declare that the individual named on this affidavit and I are eligible for the coverage requested. I understand the benefit elections made based on this affidavit are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

I understand that:

- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines
- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

I also understand that if I fail to report on required forms a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This affidavit supersedes all forms and submissions I previously made for PEBB coverage for the individual named on this affidavit. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims. I certify under penalty of the State of Oregon laws that the foregoing is true and accurate to the best of my knowledge

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## 4. Notary Stamp

State of: \_\_\_\_\_, County of: \_\_\_\_\_

Sworn & Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Signature of Notary Public: \_\_\_\_\_ Official title: \_\_\_\_\_

You must submit a midyear change form to your agency within 30 days of the date when an individual you provide coverage to is no longer PEBB eligible. Individuals will be removed prospectively from coverage the last day of the month in which the agency receives the midyear change form from the employee. If you do not report changes of eligibility that occur before open enrollment, you may face civil or criminal charges for fraud, and PEBB may rescind coverage.

**Submit completed form to your agency payroll or university benefits office.**

**Keep a copy of your benefit forms for your records.**

**Any alteration of this form may result in it being ineffective.**