pebb
Public Employees' Benefit Board

Grandchild by Affidavit

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Only use this form to add coverage for a grandchild of an eligible dependent child of yours, your spouse's or your domestic partner's. See the Summary Plan Description for more information: www.PEBBinfo.com.

- **Newly Eligible, Newly Hired and Active Employees** requesting a midyear change: You must submit the Employee Enrollment or Midyear Change form ***and*** this notarized affidavit to your agency/university payroll office, or the child will not receive coverage.
- **Open Enrollment**: You may enroll your child/grandchild through PEBB's online system at www.PEBBenroll.com. The child's enrollment will take effect only after you submit this notarized affidavit to your agency/university payroll office during Open Enrollment or within seven days following the close of Open Enrollment.
- A grandchild 18 years of age or older may not be added to PEBB coverage unless there is a court order documenting responsibility of the child beyond the age of 18 presented with this affidavit.
- Use one Affidavit per Grandchild

Contact information *(You must complete all fields, please print clearly.)*

PEBB benefit number (P########), OR#, University ID or Lottery ID

Last name | First name | Middle | Gender ◯ M ◯ F ◯ Other

☐ Check if new address

Contact address | Apartment # | City | State | ZIP

Residence ZIP code | Work ZIP code | Work email | Personal email (optional)

Date of birth (mm/dd/yyyy) | Work phone | Home phone (optional)

Certification

☐ I certify that my grandchild is a biological/adopted child of my PEBB-eligible child ***and*** meets ***all of*** the following criteria:

- My eligible child is enrolled in PEBB healthcare coverage *(If not the grandchild is ineligible)*.
- The grandchild's eligible parent is not older than age 26, is unmarried, and without a Domestic Partner.
- Both the grandchild ***and*** eligible parent *(my PEBB eligible child)* live in my household.
- Both the grandchild ***and*** eligible parent are listed on my current Federal taxes and are my current IRS tax dependents.

Name of my PEBB eligible dependent who is the biological/adopted parent of my grandchild: _____

Date my grandchild and eligible dependent child came to live with me: _____

Dependent grandchild information

Last name	First name	Middle	Date of birth (mm/dd/yyyy)

Employee signature and authorization

I declare that the individuals listed on this Affidavit and I are eligible for the coverage requested. I understand the benefit elections made on this application 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 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.
- If I fail to report 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.
- You must submit a midyear change form to your benefit office within 30 days of the date when an individual you provide coverage for is no longer PEBB eligible. If your notice is late, you and your qualified beneficiaries may lose the right to elect COBRA.
- This affidavit supersedes all forms and submissions I previously made for PEBB coverage for individuals named.
- If you DO NOT want premiums deducted on a pre-tax basis, initial here. _____

☐ I certify under penalty of State of Oregon laws that the information presented on this form is true and accurate to the best of my knowledge and belief. I understand that this information may be subject to audit by PEBB and that findings are subject to penalty for false claims.

_____ _____

Employee signature Date

Submit completed form to your agency or university payroll office after being notarized.

Keep a copy of your benefit forms for your records.

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

Notary stamp

State of _____**, County of** _____

Sworn and subscribed before me this _____ **day of** _____**20**_____

Signature of Notary Public: _____

Printed name and official title: _____