PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Affidavit of Child Dependency

- Office Use Only -
Approved by ___ Date___
Effective Date_____

Use this affidavit to affirm your legal responsibility for a dependent child. Examples: a foster child; a child for whom a court has assigned you responsibility. **Do not use this form to affirm legal responsibility for a grandchild newly enrolled in 2011**; use the Grandchild Affidavit for that purpose. See the Summary Plan Description for requirements on eligibility of dependent children: www.oregon.gov/DAS/PEBB/SPD.shtml.

- **Open Enrollment**: You may enroll the child for coverage through the online system; however, the 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 the enrollment or Midyear Change form, this affidavit and required documentation to your agency within the allowed time, or the agency will not enroll the child for coverage.
- **End of coverage**: Coverage ends the last day of the month of when legal responsibility ends.

Submit completed affidavit and a copy of required documentation to your agency payroll or university benefits office. Use one affidavit per dependent child.

1. Contact Information

PEBB Benefit Number (P########), Employee ID, University ID

Last Name	First Name	MI	Agency #	Gender ☐ F ☐ M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address	Apt #	City	State	Zip	County

Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail (optional)

Date of Birth (mm/dd/yyyy)	Work Phone	Home Phone (optional)

2. Dependent Child Information

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy)

Relationship to you	Date of Initial Legal Responsibility	Date Legal Responsibility Ends

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. The exception to prospective removal from coverage is when an ex spouse, ex domestic partner or any child becomes ineligible for coverage because of divorce or dissolution of partnership. In this exception, the ineligible individuals will be removed from coverage the last day of the month in which the divorce or dissolution occurred. Late submission may affect your income taxes. In the case of retroactive terminations, you may be responsible for claims paid for the individual during the period of ineligibility. 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.

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

State of _____ **, County of** _____

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

Signature of Notary Public: _____

Official Title: _____

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