

Date:

To:

From: Darla A. Bello, Health Benefits Officer

Subject: Dependent Coverage for Medical, Dental, and Vision Insurance

One or more of your dependents has attained or will soon attain the age of 19 years. A review of the Public Employees' Medical and Health Care Act (PEHMCA) has determined that the dependents will remain eligible for CalPERS health insurance coverage until age 23 unless they have entered the military, married, or obtained other health coverage. You may choose to delete any dependent off of your insurance at any time after they have reached the age of 19 years.

In order for these dependents to be eligible to continue on the dental and vision insurance provided by the City of Reedley, they must be a full-time student attending an accredited school of higher education. You may be asked to provide school records as verification of enrollment and attendance. You are required to complete an Affidavit of Eligibility for Overage Dependents form and have it notarized. A copy is attached.

Kay Pierce is a Notary Public and will be able to assist you with notarizing the form.

AFFIDAVIT OF ELIGIBILITY

(OVERAGE DEPENDENTS)

In order for dependents (19 to 22 years of age) to be eligible for Delta Dental Insurance or Vision Service Plan coverages, the dependents must meet the following conditions: **1) the dependent is a full-time student at an accredited school, 2) the dependent is unmarried, and 3) the dependent is not enlisted in the military.**

I therefore, swear (or affirm) under penalty of perjury that _____ (dependent's name), is eligible to remain covered as a dependent on my insurance in accordance with the conditions listed in the paragraph above.

I recognize that this affidavit is a legally-binding document and accept responsibility for notifying my Health Benefits Officer immediately if there are any changes pertaining to this dependent's status. I also agree to provide supporting documentation, such as school records, when requested by Delta Dental, Vision Service Plan or the City of Reedley at any time as long as the dependent is enrolled in any insurance plan provided by the City of Reedley.

Employee Signature: _____

Date Signed: _____ Daytime Phone: (_____)_____

Social Security Number: _____

Certificate of Acknowledgement

State of California, County of Fresno _____

On _____ before me, _____
(Name and Title)

personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. WITNESS my hand and official seal.

Signature _____ (Seal)

FOR FINANCE DEPARTMENT USE ONLY

Affidavit received on _____, by _____
(Signature of Health Benefits Officer)

(Please return this form to the Finance Department)