



0123456

Affidavit of Grandchild Eligibility

Before me, _____, a Notary Public in and for said County, in said State,
personally appeared _____ who, being sworn, did depose and say as follows:

The dependent child, whose name is listed below, is my grandchild. S/he meets the eligibility criteria for a grandchild as defined in the PEBC healthcare plan summary plan description: "[y]our *unmarried* grandchild (child of your child) under age 26 who, at the time of enrollment, is your dependent for federal income tax purposes, without regard to income limitations."

I certify under penalty of perjury that the information contained in this Affidavit is true, correct and current. I agree to notify my employer's Human Resources Department, in writing, of any change in relationship status that would make my dependent ineligible for healthcare within 30 days of such change. I understand that the information contained in this Affidavit is confidential and is being provided for the sole purpose of determining eligibility for healthcare coverage. I further understand that a false statement may result in termination of healthcare coverage and include disciplinary action up to and including employment termination.

Employee Name (please print)

Employee Signature

Date

Name of Dependent Grandchild(ren) (please print)

If more than one Grandchild enrolled, list here:

THIS DOCUMENT MUST BE NOTARIZED. PLEASE HAVE THE SECTION BELOW COMPLETED, SIGNED, AND SEALED BY A NOTARY PUBLIC.

Subscribed and sworn to before me this _____ day of _____, 20____.

[NOTARY SEAL]

My commission expires:

_____ 20____

County

State

IMPORTANT: This document is for use when a grandchild is enrolled in the plan prior to filing the current year federal tax return. A copy of the tax return must be provided as soon as it is filed to avoid removal of the grandchild from the plan.