0123456

PUBLIC EMPLOYEE BENEFITS COOPERATIVE

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.