



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com

For AMO Official Use Only

Received Date: _____

Received By: _____

AFFIDAVIT OF SUPPORT FOR DEPENDENT STUDENT

TO BE COMPLETED BY THE PLAN PARTICIPANT FOR EACH CHILD LISTED AS A DEPENDENT STUDENT

Eligibility requirements for a dependent student are as follows:

- An unmarried child, step-child, or child under legal guardianship/ custody of Participant who is nineteen years but less than twenty-three years of age attending school on a full-time basis and dependent upon Participant for principal support and maintenance.
- School vacation periods during any calendar year, which interrupt but do not terminate what otherwise, would have been a continuous course of study in that calendar year shall be considered a part of school attendance on a full-time basis.
- Full-time shall mean the completion of twelve credit hours per semester or its equivalent. Credits completed during summer or winter sessions may be applied to any one semester in a scholastic year. Scholastic year shall mean consecutive semesters attended not to exceed one year.
- The medical benefits for an eligible dependent student shall cease once the dependent student has reached age twenty-three or fails to meet the above eligibility requirements for a dependent student. **Note: You must advise the Plan office promptly if dependent student status changes.**

PARTICIPANT INFORMATION

Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Home Telephone No.:	Cellular Phone No.:	
E-mail:		

PLEASE BE AWARE THAT YOU ARE REQUIRED TO NOTIFY THE PLAN OFFICE IMMEDIATELY IF ANY CHANGE IN DEPENDENT STUDENT STATUS OCCURS. FAILURE TO DO SO MAY RESULT IN LOSS OF ELIGIBILITY FOR MEDICAL BENEFITS AND MAY REQUIRE REIMBURSEMENT OF ANY BENEFITS PAID FOR MEDICAL SERVICES ON DEPENDENT STUDENT'S BEHALF.

DEPENDENT STUDENT INFORMATION

Dependent Student's Name:	SSN: XXX-XX-	DOB:
School Attending:	City:	State:
School Telephone No.:		
Will your dependent student be enrolled in 12 credits or more from 1/1/2010 – 8/31/2010?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will your dependent student be enrolled in 12 credits or more from 9/1/2010 – 12/31/2010?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SIGNATURES

Participant Signature:	Date:
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CERTIFICATION OF INFORMATION

I hereby attest that the student above is dependent upon me for principal support and maintenance. I further attest that this child meets the eligibility requirements of a dependent student in accordance with the rules and regulations of the AMO Medical Plan (the "Plan"). I hereby certify that the information contained herein is true. I agree to notify the Plan office of any changes that occur which may change my dependent student's coverage. I further understand that if I make false statements I may jeopardize my AMO Medical Plan benefits and coverage and will be required to return any benefits paid for medical services under the Plan. I understand that the accuracy of the information contained herein as well as my compliance with the requirement to notify the plan office of any changes that occur which may affect the status of my dependent student's coverage under the Plan may be audited at any time by the AMO Plans Internal Auditor. In the event of such an audit, I may be required to provide information including but not limited to, my dependent student's official school transcript to reflect credit hours earned for each semester or an official registrar's receipt to reflect full-time student status for each semester. I understand that my failure to provide the requested information may result in the loss of eligibility for medical benefits and/or the reimbursement of benefits that have been paid under the AMO Medical Plan.

NOTARY PUBLIC

STATE OF _____)
COUNTY OF _____)

The foregoing instrument was acknowledged this _____ day of _____, 20____, by _____ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

Signature of Notary Public

Print, Type, or Stamp Commissioned Name of Notary Public

Date Commission Expires

NOTARY SEAL

Personally Known

Produced Identification

Type of Identification: _____