



AMERICAN MARITIME OFFICERS (AMO) PLANS

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For AMO Official Use Only

Received Date: _____

Received By: _____

AFFIDAVIT FOR DEPENDENT CHILD

TO BE COMPLETED BY THE PLAN PARTICIPANT FOR EACH CHILD BETWEEN THE AGES OF 19 AND 26 LISTED AS A DEPENDENT

Eligibility requirements for a dependent child are as follows:

- A child, step-child, or child under legal guardianship/custody of Participant who is nineteen years but less than twenty-six years of age and who is a full-time student.
- A child, step-child, or child under legal guardianship/custody of Participant who is nineteen years but less than twenty-six years of age and who is not a full-time student and who does not have access to health coverage through his or her employer.
- The medical benefits for an eligible dependent shall cease once the dependent has reached age twenty-six or fails to meet the above eligibility requirements. **Note: You must advise the Plan office promptly if dependent status changes.**

IN ORDER FOR THIS FORM TO BE ACCEPTED, YOU MUST ANSWER EVERY QUESTION

PARTICIPANT INFORMATION

Name:	SSN: XXX-XX-	DOB:
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PLEASE BE AWARE THAT YOU ARE REQUIRED TO NOTIFY THE PLAN OFFICE IMMEDIATELY IF ANY CHANGE IN DEPENDENT 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'S BEHALF.

DEPENDENT INFORMATION

Dependent Name:	SSN:	DOB:
If dependent does not have a SSN please explain why:		
Is dependent employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time (30 hours or more per week).	
If yes, name of Employer:	Employer Phone Number:	
Address of Employer:		
City:	State:	ZIP Code:
Does your dependent have access to health coverage through employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date of coverage:
Is your dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expected date of graduation:

SIGNATURES

Participant Signature:	Date:
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CERTIFICATION OF INFORMATION

I hereby attest that this child meets the eligibility requirements of a dependent 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'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'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 additional information. 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	<input type="checkbox"/> Personally Known <input type="checkbox"/> Produced Identification Type of Identification: _____