AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
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For AMO Official Use Only
Received Date: ________
Received By: __________

DEPENDENT PARENT'S MEDICAL BENEFITS AFFIDAVIT OF SUPPORT, EARNINGS LIMITATION AND COORDINATION OF BENEFITS

In order for a dependent parent to be considered eligible for the medical benefits under the AMO Medical Plan (the "Medical Plan,") the dependent parent must meet the definition and requirements of a dependent in accordance with the rules and regulations of the Medical Plan. You are required to notify the Plan office immediately if any changes in dependent parent status occur. 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 parent's behalf. The medical benefits for an eligible dependent parent shall cease once the eligible dependent parent becomes eligible to participate in any national, state or other governmental plan of health insurance or care including Medicare, and Medicaid.

**** PLEASE ATTACH REQUIRED DOCUMENTS TO THIS FORM ****

PARTICIPANT INFORMATION		
Participant's Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Home Telephone No.:	Cellular Phone No.:	
E-mail:		
Do you now or have you ever had any other dependents at any time eligible for coverage under this Plan?		☐ Yes ☐ No
Is the dependent parent listed as a dependent on your annual federal income tax returns?		☐ Yes ☐ No

The Plan requires a copy of a completed and signed annual tax return to claim parent as a dependent under the Plan.

DEPENDENT PARENT INFORMATION		
Dependent Parent's Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Is the dependent parent employed? ☐ Yes ☐No	If yes, annual income: $ ______________________________	
Is the dependent parent eligible to participate in Medicare, Medicaid, or any other national, state or governmental health insurance plan?		☐ Yes ☐ No

SIGNATURES	
Participant Signature:	Date:

CERTIFICATION OF INFORMATION

I herby attest that I am an unmarried Participant of the AMO Medical Plan and currently provide principal support and maintenance to my parent named above. I hereby attest that I have no other dependents or former dependents who are or were at any time eligible for coverage under the AMO Medical Plan. I understand that the American Maritime Officers Medical Plan does not provide health coverage to any dependent parent who has earnings from gainful employment that are in excess of the amount permitted under the Rules and Regulations of the AMO Medical Plan. I will notify the Plan of any changes that occur which may change the status of my dependent parents coverage. I hereby certify that the information contained herein is true. I further understand that if I make false statements to the American Maritime Officers Medical Plan, I may jeopardize my Medical Plan benefits and coverage and will be required to return any benefits paid for medical services. The information provided is subject to the audit and verification of the Plan office.

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: ______________________