Embrace better health®

AFFIDAVIT OF EXTENDED DEPENDENT ELIGIBILITY
JHS (AGE 26– 30)
Florida Statute 627.6562

EMPLOYEE INFORMATION

Name: _____ **AvMed Member ID #**:_____

Phone: _____ **Email**: _____ **Date of Birth**: _____

DEPENDENT INFORMATION

Dependent's Last Name	First Name	Date of Birth	Sex	AvMed Member ID #

Required: By checking off each item below, I hereby certify that YES, the dependent identified above:

- ☐ Is my child; and
- ☐ is unmarried; and
- ☐ has no dependents (children) of his or her own; and
- ☐ is a resident of the State of Florida or a full-time or part-time student; and
- ☐ does not have other insurance coverage and is not entitled to Medicare; and
- ☐ since the end of the calendar year my child turned 25, he/she has been continuously covered by my plan, or other creditable coverage without a gap of more than 63 days
- ☐ I have attached supporting documentation in the form of one of the following: *Proof of FL residency or school registration and agree to provide the documents listed or any other documents, when requested.

Statement of Non-Eligible Dependent:

- ☐ I certify that the dependent identified above **is NOT an eligible dependent under the requirements** of the Florida Statute (FSS 627.6562). (Your dependent will be cancelled retroactive to December 31st, and no further documentation is required.)

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying **JHS** and/or **AvMed** immediately if there are any changes pertaining to this child's status as my dependent during the plan year. I acknowledge that this form expires 12/31 of the plan year that I am certifying, or as of the date the dependent no longer meets eligibility criteria under the Plan's rules, whichever comes first. I have attached supporting documentation in the form of one of the following: ***proof of FL residency or school registration** and agree to provide the documents listed or any other documents, when requested by **JHS** or its insurers at any time as long as the child is enrolled as my dependent. I have provided this information for use by AvMed for the purpose of determining eligibility and participation in **JHS** Group Health Plan, and retroactive denial of claims previously processed. I hereby certify, under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge. **ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

***Please submit the Affidavit and eligibility documents via email to**

OADAnnualEligibility@avmed.org

⟶Employee Signature:_____**Date**_____

SWORN TO and subscribed before me this _____day of _____, 20_____,

⟶ By (EMPLOYEE NAME REQUIRED): _____

Who is personally known to me _____ who produced a current driver's license_____ who produced _____as identification
Notary Public Signature_____ Notary Public name_____
My commission expires_____ _____