Embrace better health®

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

MIAMI-DADE COUNTY EMPLOYEE INFORMATION

Name: _____ AvMed Member ID #:_____

Contact Phone: _____ Date of Birth: _____ Email: _____

DEPENDENT INFORMATION

_____

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

By checking each item below, I hereby certify that 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.

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 January 1 of the plan year you are certifying, and no further documentation is required.)

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying **Miami Dade County** 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 Miami-Dade County** 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 Miami-Dade County's 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.

*You may submit the Affidavit and eligibility documents in the enclosed envelope, or scan it to **OADAnnualEligibility@avmed.org**

Employee Signature:_____**Date**_____

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

By: _____

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_____