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 #

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 retroactive to January 1, 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.**

***You may submit the Affidavit and eligibility documents in the enclosed envelope or email them 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_____