MACOMB COUNTY
DENTAL COVERAGE
AFFIDAVIT OF ADULT CHILD (19-26) ELIGIBILITY

This affidavit, when signed and returned, will serve as a certification of eligibility of dependent status for the person(s) listed below (please print). PLEASE NOTE: you may be selected during a random audit and required to provide a copy of your tax return to support your election.

Employee Name: ______________________ ______________________
First Name Last Name

Employee ID: ______________ Department: ______________

Dependent Name: ______________________ ______________________
First Name Last Name

Phone Number: ______________ Email: ______________

Section I: Adult Child Benefits

Please answer the following question. Your response or lack thereof will impact the dental coverage of your adult child (age 19-26).

1. Is your adult child a claimable dependent? Yes ☐ No ☐

By selecting no, I understand my adult child will be cancelled off my **dental** plan. Please complete benefit change form found on the intranet/internet.

Please note that if you choose to cover your adult child you may be required to provide a copy of your tax return for the prior year to support maintaining coverage.

Section III: Employee's Acknowledgment

As an employee of the County of Macomb, I certify under penalty of perjury, that all the information I have provided on this form, and any required supporting documentation, is true and correct. I understand that any false or misleading information will lead to the termination of medical benefits for the listed dependent and possible discipline for the employee. I also acknowledge, that if at any time throughout the year my dependent no longer meets the eligibility, I must complete the required paperwork to cancel coverage for that dependent within 60 days. Failure to do so, will result in my repayment of incorrect benefit payments to the County of Macomb.

______________________ ______________
Employee Signature Date