Internal Services

Department of Personnel Services

Employee Benefits Office
AnnMarie Meyer, Manager

County of Sacramento

Bradley J. Hudson,
County Executive

David Villanueva,
Chief Deputy County Executive

David Devine,
Department Director

DEPENDENT CERTIFICATION AFFIDAVIT

_____ _____ _____
Employee's Name Date of Birth Employee ID (or Special District)

If your child is between the ages of 19-26, s/he must be enrolled as either a Full-Time Student or an Adult Dependent to be eligible for coverage. Eligibility requirements are listed below:

ADULT DEPENDENT: Child (natural, step, adopted, legal guardianship, and/or foster) of employee, spouse, or domestic partner that is over the age of 19 and under the age of 26, **that does not have access to group coverage other than coverage through a parent's employer.** Adult dependents may be covered regardless of marital status or whether or not they reside with the employee. Spouses and children of adult dependents are not eligible. The term "domestic partner" is defined by Section 297 of the California Family Code.

OR

FULL TIME STUDENT: Dependents attending school as full-time students in an accredited secondary school, college, or university, **who are unmarried and have not attained 24 years of age are also eligible**. Generally, 12 units represent full-time student status. Special rules apply for disabled dependents and full time students that become disabled.

If your child meets the eligibility requirements of an Adult Dependent, enter your dependents name and check the box below. Both of you must sign the certifications.

If your child meets the eligibility requirements of a full time student, return this completed form with a copy of the current verification* of full-time enrollment. Your child does not need to sign the Dependent Certification.

- _____ _____ ☐Adult Dependent (Sign certification below)
  Dependent's Name Date of Birth ☐Full time Student (Return with verification*)

*Verification must be submitted each semester or quarter and list the child's name, school attending, and number of units enrolled, or indicate that enrollment is full-time. It is the employee's responsibility to provide such documentation. Employees may not be reminded of their responsibility. Failure to provide required documentation will result in termination of coverage for the dependent student and inability to add the dependent student until the next Open Enrollment period or qualified status change event.

DEPENDENT CERTIFICATION

Are health benefits available through your employer? ☐Medical ☐Dental ☐No _____ _____
Employer's Name Employers Phone Number

Dependent's Signature _____ **Date** _____

EMPLOYEE CERTIFICATION

I, _____ (employee), hereby certify the dependent listed above meets the eligibility requirements as stated by the COUNTY OF SACRAMENTO (County) and Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care Education and Reconciliation Act (HCERA). I acknowledge that if the dependent listed above does not meet the eligibility requirements, I will be liable for full repayment of any employee health care benefits and/or premiums paid on behalf of the ineligible dependent enrolled on my plan and I may be subject to legal remedies and/or disciplinary action for falsifying employment related documents. I also understand it is my responsibility to notify the County within 30 days of the above dependent gaining access to other group coverage.

Employee Signature_____ **Date** _____

Received By_____ **Date** _____