ST. PAUL ELECTRICAL WORKERS HEALTH PLAN

Dependent Affidavit Form

Print Participant Name _____ Participant Date of Birth _____

Print Dependent Full Name _____ Dependent Date of Birth _____

Dependent Social Security Number _____

An eligible dependent may include a child under the age 26 even if the dependent no longer lives with the covered participant, is not a dependent on the participant's tax return, is not a full time student, is employed or married (the dependent's spouse and children are not eligible under PPACA). A child is defined as a natural child, stepchild, foster child, adopted child and in some cases a grandchild. If you are unsure if your dependent would be considered an eligible dependent for coverage under the Plan, contact the Plan office.

I declare that I am an eligible dependent under the age 26 as defined in the Patient Protection and Affordable Care Act (PPACA) and under St. Paul Electrical Workers Health Plan (Plan).

☐ I request coverage under the SPEW Health Plan

☐ I decline enrollment in The Plan at this time

Do you reside with the participant? ☐ YES or ☐ NO
(If NO please write address & phone number on this form)

If you elect YES to continue insurance does the dependent have other insurance?
Yes ☐ or No ☐
(If **YES** please provide detail insurance information on the back of this form)

Return this affidavit via the enclosed envelope.

Declaration and Acknowledgement

We, the undersigned, hereby acknowledge the information set forth above is true and correct to the best of our knowledge. We agree to inform the St. Paul Electrical Workers Health Plan Administrator immediately of any change which occurs in this information. We understand that misrepresentation will result in an obligation to repay Plan benefits paid incorrectly, plus the cost of recovery and removal from the Plan.

Dependent Signature _____ Date _____

Participant Signature _____ Date _____

This Dependent Affidavit form is update on an annual basis, no later than September30th.
02/21/18