AFFIDAVIT OF OTHER AVAILABLE COVERAGE

Submit Form to:
Employee Benefits Unit
P.O. Box 6100
Hauppauge, NY 11788

In addition to the EMHP's extension of coverage to full-time college students, the Patient Protection and Affordable Care Act (PPACA) allows certain eligible young adults, between the ages of 19 - 26, to continue to receive coverage through his/her parent's group health benefits until age 26. This young adult coverage is subject to all terms and conditions of the applicable health benefits plan. The plan follows the Internal Revenue Code's definition of dependent as natural or legally adopted children or a stepchild. The dependent can only enroll under the plan in which his/her parent is currently enrolled. (Refer to the EMHP Benefit Booklet for complete definition/requirements)

Directions: To enroll your dependent [or for enrollment to continue until age 26], please complete this form and return it to the Employee Benefits Unit along with a completed Health Benefits Transaction Form to establish/maintain eligibility.

Name and Mailing Address of Dependent:	Social Security Number (Required):
	Telephone Number (with area code)

PARENT ENROLLEE INFORMATION

Name and Mailing Address of covered parent:	Social Security Number (Required):
	Telephone Number (with area code)

Parent enrolled under the following plan:
☐ EMHP ☐ HIP ☐ Empire Direct

To qualify for coverage of an dependent answer all of the following questions:

1. My dependent:
   a. Is a natural or adopted child of a current Suffolk County enrollee. ☐ YES ☐ NO
   OR
   b. Is a stepchild of a current Suffolk County enrollee ☐ YES ☐ NO

2. My adult child is currently enrolled as a full-time college student ☐ YES ☐ NO
   Name of College_____ Graduation Date _____

3. My dependent is covered under his/her own insurance plan.* If so: ☐ YES ☐ NO
   Name of Carrier/Plan: _____
   Carrier/Plan Address: _____
   _____
   Group/ID Number: _____ Effective Date: _____
   Termination Date (If terminated since last enrollment): _____

4. My dependent is also covered under his/her natural parents' or spouses insurance plan.* If so: ☐ YES ☐ NO
   Name of Carrier/Plan: _____
   Carrier/Plan Address: _____
   _____
   Group/ID Number: _____ Effective Date: _____
   Termination Date (If terminated since last enrollment): _____

*** NOTE**: If this coverage changes, please notify Employee Benefits Unit in writing.

Please complete reverse side

YOUR COVERAGE WILL TERMINATE WHEN:

1. You voluntarily elect to terminate your coverage by sending notice to the Employee Benefits Unit;
2. Your parent is no longer enrolled in one of the County's health plans; or
3. As a stepchild your natural parent no longer meets the eligibility requirements for Coverage.

That I hereby affirm the forgoing statement is true, under the penalty of perjury and hereby agree to indemnify and make whole Suffolk County, any of the Suffolk County provided health plans, its heirs and assigns against any and all liability and/or loss arising out of any inaccuracy or alleged inaccuracy of the foregoing statement and/or documentation provided.

Enrollee Signature: _____

Printed Name: _____

Date: _____

Sworn to Before Me
This _____ day of _____, 201_____

_____
Notary Public

Please complete this form and return it to the Employee Benefit Unit at P.O. Box 6100, Hauppauge, NY 11788. Please provide the necessary documentation to establish eligibility. (i.e. birth certificate, adoption decree, etc.)