PEBB Affidavit of Dependency Form
Instructions
www.oregon.gov/DAS/PEBB

Complete and notarize this form to request benefit plan coverage for an eligible child whom you or your spouse or domestic partner are obligated to support, or contribute to the support of, and who is not a biological or adopted child. For detailed dependent information refer to the PEBB Benefits Handbook or web site.

- Submit this form along with either a PEBB enrollment or update form.
- This notarized affidavit must be on file **within 5 business days** of submission of this enrollment election. If not, coverage for the dependent child will terminate retroactive to the effective date.
- You must provide documentation of court orders or other supporting documentation that establishes responsibility for the child's support.

SECTION A – EMPLOYEE INFORMATION

- Complete each item in this section

SECTION B – CHILD INFORMATION

- Complete each item in this section.

SECTION C – DECLARATION OF DEPENDENT ELIGIBILITY

- Read this entire section carefully to determine eligibility.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Notarize, sign and date
- Make a copy for your records and submit to your agency/university payroll or benefit office.
- If you are a **Self-pay Participant or COBRA** submit your forms to BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240.
- Sending your forms to the wrong address will delay your change.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Affidavit of Dependency Form

SECTION A - EMPLOYEE INFORMATION			
LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, OUS#, BENEFIT #)
DATE OF BIRTH (MM-DD-YYYY)		GENDER ☐ FEMALE ☐ MALE	
RESIDENCE ADDRESS ☐ New Address		CITY	STATE ZIP
		COUNTY	HOME PHONE
MAILING ADDRESS (if different from above) ☐ New Address		AGENCY	WORK PHONE
E-MAIL ADDRESS			

SECTION B - CHILD INFORMATION			
LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, OUS#, BENEFIT #)
DATE OF BIRTH (MM-DD-YYY)	CHILD'S RESIDENT ADDRESS		
RELATIONSHIP TO YOU	DATE OF YOUR RESPONSIBILITY		

SECTION C- DECLARATION OF DEPENDENT ELIGIBILITY

I declare that:

- This child is not married or have a domestic partner
- I or my spouse or domestic partner claims the child as an IRS dependent.

I declare that the child also meets one of the following criteria:

- Is under the age of 19 at the end of the calendar year, lives in the home of the eligible employee and qualifies under OAR 101-010-0005 and you expect to contribute 50% or more of the child's support for current and future tax years; or
- Is age 19 to 24 and meets the IRS definition of a dependent child attending school full time (The student child must be a citizen, national or resident of the United States. No coverage provided to any individual who fails to satisfy citizenship or residency requirements); or
- Is age 19 to 24 and the eligible member provides or expects to provide more than half the child's support for the year, and the child lives in the eligible member's home for at least six months of the year; or
- Is age 19 to 24 and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability; or
- Is age 24 or older and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability that existed before the child attained age 24. The child must have had continuous individual or group medical coverage prior to attaining age 24 and until the PEBB effective coverage date.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

I understand that:

- It is my responsibility to notify PEBB within 60 days of when the dependent child no longer meets eligibility requirements.
- That PEBB or the insurance company may ask, at any time, if the eligibility requirements continue to be met.
- Any misrepresentation of fact is grounds for denial or immediate cancellation of coverage for me, my family and the named child without the opportunity to enroll until the following open enrollment.
- The insurance company is entitled to recover from me any expenses for claims paid for this ineligible dependent child.

I Certify that:

- The named child meets the requirements of eligibility.
- Under penalty of perjury under the laws of the State of Oregon that the foregoing is true and accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

State of_____, County of _____

Sworn and Subscribed before me this _____ day of _____ 20_____

Signature of Notary Public_____

Official Title: _____