

CERTIFICATION OF DEPENDENT ELIGIBILITY

I, _____ submit this Confirmation of Dependent Eligibility to establish _____ as my dependent according to the eligibility requirements of _____ School District.

Check the appropriate box.

My child is ***unmarried and a full-time student*** (normally 12 units) at an accredited educational institution.

My child is permanently disabled and incapable of self-sustaining employment. My child is or is not covered at this time under the Medicare disability program. IF YOUR CHILD IS NOT COVERED BY MEDICARE, PLEASE ATTACH A LETTER FROM THE CHILD'S PHYSICIAN EXPLAINING THE DIAGNOSIS, EXTENT OF DISABILITY AND PROGNOSIS.

- I understand I have an obligation to notify my district immediately of my dependent's failure to maintain full-time student status at an accredited educational institution or of a change in my disabled dependent's condition.
- I understand that the Plan reserves the right to request back-up documentation at any time.
- I also understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statements contained in this Confirmation.

I declare, under penalty of perjury, that the foregoing is true and correct.

Employee Name

Name of Dependent

Employee Address

Employee Signature

Date

Employee Social Security Number

Dependent Social Security Number