

Subscriber's Name: \_\_\_\_\_ Dependent's Name: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Health Insurance ID#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## DEPENDENT ELIGIBILITY VERIFICATION AFFIDAVIT

**Please Note: This affidavit will only be accepted if signed by the Subscriber.**

I hereby certify that \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Name of Dependent) (Social Security Number) (Date of Birth)

**IS A STUDENT meeting certain eligibility requirements while enrolled at:**

\_\_\_\_\_  
(Educational institution: high school, college, university, other)

\_\_\_\_\_  
(City/Town) (State)

For the semester \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_ or school year \_\_\_\_\_

Expected Graduation Date: \_\_\_\_ / \_\_\_\_ **OR**  No longer student

I hereby certify that the information provided above is correct. I understand that I am obligated to inform my employer of any change in the noted dependent's status. To ensure accuracy, I acknowledge and agree that Primex<sup>3</sup>Health or my employer, may investigate the status of the noted dependent during the period in which the dependent is claiming this standing. I understand that any misrepresentation in the information I have provided above will permit Primex<sup>3</sup>Health and/or my employer to terminate the dependent's coverage and seek any other legal remedies available to Primex<sup>3</sup>Health and/or my employer.

I understand that the dependent's coverage may not be effective until a signed affidavit is returned to Primex<sup>3</sup>Health.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Subscriber

**PLEASE RETURN COMPLETED FORM TO Paula Baumel, Personnel Division**