AFFIDAVIT OF DEPENDENT ELIGIBILITY

(Age 18 to 25)

DEPENDENT'S STATEMENT

I declare that as of _____, 20____, that I am under the age of twenty-six (26) and I am not employed and/or my employer does not offer health insurance benefits.

I DECLARE UNDER PENATLY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENT IS TRUE AND CORRECT

Date: _____ Dependent's Name: _____

Dependent's Signature: _____

EMPLOYEE'S STATEMENT

I declare that the dependent named above is an eligible dependent of mine as defined by the Imperial County's Health Plan Document. I understand that I must notify the Imperial County Human Resources Department within 30 days of the date that this dependent becomes eligible for health insurance benefits under his/her employer. I understand and acknowledge that a failure to report such information can result in the Imperial County terminating coverage retroactively and seeking to recover from me any and all losses that it suffers as a consequence.

I DECLARE UNDER PENATLY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENT IS TRUE AND CORRECT

Date: _____ Employee's Name: _____

Employee's Signature: _____