AFFIDAVIT OF OVERAGE DEPENDENT ELIGIBILITY (AGE 26-30)

Florida Statute 627.6562

JACKSON HEALTH SYSTEMS EMPLOYEE INFORMATION

Name: _____ Jackson Health Systems Employee ID#: _____

Contact Phone: _____ Date of Birth: _____ Email: _____

DEPENDENT INFORMATION

Dependent's Last Name: _____ First Name: _____

Date of Birth: _____ Aetna Member ID #: _____

By checking each item below, I hereby certify that the dependent identified above:

[ ] Is my child (birth certificate)
[ ] Is unmarried
[ ] Has no dependents (children) of his or her own
[ ] Is a resident of Florida or a full-time/part-time student (Florida Driver's License or School Registration)
[ ] Does not have other insurance coverage and is not entitled to Medicare
[ ] Has been continuously covered without a gap of more than 63 days since age 25

Statement of Non-Eligible Dependent:

[ ] I certify that the dependent identified above is **NOT** an eligible dependent under Florida Statute 627.6562.

I recognize that this affidavit is legally binding and accept full responsibility for notifying Jackson Health Systems of any changes.

This form expires 12/31 of the plan year or when the dependent no longer meets eligibility criteria.

Supporting documentation (proof of FL residency or school registration) must be attached.

Submit completed affidavit and documents to: VerifyMyJHSDependent@aetna.com

Employee Signature: _____ Date: _____

SWORN TO and subscribed before me this _____ day of _____, 20____

By _____

Who is personally known to me [ ] who produced a current driver's license [ ] who produced _____ as identification

Notary Public Signature: _____ Notary Public Name: _____

My commission expires: _____