Lakeland Community College
Adult Dependent Eligibility Attestation Form

Please complete and submit this form to the Human Resources office if you are enrolling an adult dependent or continuing coverage for an adult dependent between ***ages 26 and 28*** under Ohio state law. This attestation will allow you to confirm that the adult dependent meets the eligibility criteria for coverage and summarizes your obligations to the College.

The following summarizes the Ohio state law rules for covered adult dependents. Note all criteria must be met.

Under State Law, the child must be unmarried and must:

1. Be my child as defined under the plan, which includes my natural child, stepchild, child placed for adoption, legally adopted child or my child for which either I or my spouse are legal guardian or custodian or any child who, by court order, must be provided health care coverage by me or my spouse; ***and***
2. Have not yet reached his/her ***28th*** birthday; ***and***
3. Be a resident of this state or a full-time student at an accredited public or private institution of higher education; ***and***
4. Is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; ***and***
5. Is not eligible for coverage under Medicaid or Medicare.

Note that eligibility will continue past the age limit for adult dependents that are unmarried and primarily dependent upon the employee for support due to a physical handicap or mental retardation which renders him/her unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. Employees must notify HR of an Eligible Dependent's desire to continue coverage within 31 days of the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

By signing this attestation I agree to all of the following:

- My adult dependent child meets all of the above eligibility criteria as indicated **AND** a copy of a birth certificate and/or any additional legal documentation confirming his/her eligibility is included, or is on file with the College.

- I will provide the College with certification of continuing eligibility annually, if requested. I understand that the College will automatically terminate any covered adult dependents under the plan if my response is not received within 60 calendar days from the date of the request.

- I understand that coverage terminates at the end of the month when the adult dependent no longer meets the criteria specific above.

- I agree to notify the College immediately when my adult dependent no longer meets the criteria specified above.

- I understand that, upon enrollment of the adult dependent, my monthly contribution may be adjusted to reflect the additional dependent coverage, if applicable.

- I understand that because my adult dependent child is continuing coverage due to state law, I will be required to pay a monthly surcharge to the College as allowable.

Be signing this attestation, I understand that knowingly furnishing incorrect or incomplete information or failing to notify the College of changes in eligibility may result in termination of my coverage and/or my dependents' coverage upon 15 days' written notice from the Human Resources office.

Signature of Employee: **Date:**

_____ _____

_____

Print Name

Name of Adult Dependent: **Date of Birth of Adult Dependent**

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*** PLEASE PROVIDE A COPY OF BIRTH CERTIFICATE OR OTHER LEGAL DOCUMENTATION SUPPORTING THE CHILD'S ELIGIBILITY DEFINITION, UNLESS THIS DOCUMENT IS ON FILE IN THE HUMAN RESOURCES OFFICE ***