PALM BEACH COUNTY
SHERIFF'S OFFICE
RIC L. BRADSHAW, SHERIFF

Affirmation of Age Based Dependent (Overage Dependent)

Name of Employee: _____
Employee ID #: _____
Name of Dependent: _____
Dependent DOB: _____
Dependent SSN: _____
Dependent Relationship: _____

Palm Beach County Sheriff's Office (PBSO) Benefit Plans allow *medical and dental* coverages *[no vision]* for dependents from the age of 27 through the end of the calendar year in which they turn 30 years; if all the conditions below are met:

1. Is unmarried; **and**
2. Has no dependents (i.e. children, domestic partner, etc.); **and**
3. Is not provided health insurance coverage opportunity or covered under any other group or individual health benefit plan; **and**
4. Is not entitled to benefits under Title XVIII of the Social Security Act; **and**
5. Is a resident of Florida **OR** a full-time or part-time student; **and**

I understand the terms of my health coverage benefits may provide my dependent child continued coverage, if certain eligibility requirements are met. I, affirm that my dependent child identified above, meets all the dependent status requirements applicable to his/her age.

I also understand that if at any time my dependent no longer meets the definition of an eligible overaged dependent, I must immediately notify Benefits Division of the change.

I understand and affirm that I have provided true and official documentation; and that the dependent listed above meets the eligibility criteria, as specified by PBSO. I further understand that in the event any of the statements set forth above are not true, the benefit(s) coverage provided under this affirmation will be rescinded. I will be liable for any expenses incurred by the employer, insurer, or health entity, and I may be subject to administrative, civil or criminal sanctions.

_____	_____	_____	_____
Print Name	ID #	Signature	Date