CITY COLLEGES OF CHICAGO

Employee Dependent Eligibility Affidavit for Health Benefits Coverage

Employee/Retiree

Last	First	MI

SSN#

Dependent

Last	First	MI

SSN# | Date of Birth

Dependent Relationship (please check applicable box):

Spouse

- ☐ Legal Spouse
- ☐ Same-Sex Domestic Partner (completed Domestic Partner Application packet required)
- ☐ Legal Civil Union Partner

Date of Marriage/Civil Union:

Child*

- ☐ Natural Child
- ☐ Legally adopted child
- ☐ Stepchild
- ☐ Child for whom you or your spouse have been appointed as legal guardian

*Under the age of 26 (or until age 30 for military dependents)

I solemnly affirm under the penalties of perjury under applicable state laws that the foregoing is true and accurate. I understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the person identified as my dependent, and the termination of coverage for myself (the employee/retiree). I understand that a civil action may be brought against me for any losses, including reasonable attorney fees because of a false statement contained in this Affidavit. In addition, where permissible, employment related action may be taken against me if I am an active employee. I also understand that certified documents may be requested at a later date to validate dependency status (i.e. marriage/civil union/birth certificate, court order).

I further agree that if this dependent's status changes, I will notify the City Colleges of Chicago Benefits Division immediately to remove this dependent from my coverage.

Employee/Retiree Signature:	Date