

# Lake County Board of County Commissioners

## Dependent Age 19-26 Affidavit (Non Disabled)

|  |             |
|--|-------------|
| Employee's Name (Last Name, First Name, Middle Initial):   | Employee #: |
| Dependent's Name (Last Name, First Name, Middle Initial):  |             |
| Dependent's Date of Birth (Month, Day, Year):  |             |
| I affirm this Dependent is my:<br><br><input type="checkbox"/> Natural Child<br><input type="checkbox"/> Adopted Child<br><input type="checkbox"/> Legal Spouse's Natural Child<br><input type="checkbox"/> Legal Spouse's Adopted Child |             |
| <input type="checkbox"/> I affirm that this dependent is <b>NOT</b> eligible for medical coverage through his/her employer.  |             |

I certify that the information provided on this form is a true and a correct representation. I understand that a deliberate misrepresentation of the facts on this affidavit may result in the termination of my dependent's medical coverage. In addition, I may be held responsible for funds paid to providers on my dependent's behalf.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Subscribed and sworn to before me on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_