Dependent Eligibility Affidavit

As part of our ongoing efforts to control health care costs and to remain in compliance with VEBA's tax exempt purpose, the VEBA is taking steps to ensure that only eligible dependents are covered under our healthcare plans. To accomplish this, we are asking for verification from enrolled members who have dependents on the Plan.

Employee _____ Dependent _____
Print Print

Employee _____ Dependent _____
Signature Signature

District _____
Print

I solemnly affirm under penalty of perjury that the foregoing is true and correct and the above named individual is my dependent. I understand that the willful falsification of information contained in this affidavit may result in termination of enrollment and termination of coverage of the person identified as my dependent. Additionally, reimbursement of any medical expenses incurred by an ineligible dependent may be my responsibility.

State of California
County of _____ }

On _____ before me, _____,
Date Here Insert Name and Title of the Officer

Personally appeared _____
Name(s) of Signer(s)

_____,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to be within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executive the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Place Notary Seal Above