SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

30 ORVILLE DRIVE
SUITE D
BOHEMIA, NY 11716-2513

PHONE (631) 319-4099
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www.scmebf.org

CHERYL A. FELICE, ADMINISTRATOR

EMPLOYEE STATEMENT OF DEPENDENCE

A COPY OF DEPENDENT'S BIRTH CERTIFICATE AND SOCIAL SECURITY CARD MUST BE SUMITTED WITH THIS FORM

Employee's Name _____ BF# or Soc. Sec.# (last 4 digits) _____

Employee's Address_____
(No. and Street) (City) (State) (Zip)

Present Department _____ Office Telephone _____

Dependent's Name _____ Social Security #_____
(Must be supplied)

Birth Date _____ Marital Status_____

1. What relationship is the Dependent to you? _____

   State the status of the Dependent as: _____

   (A) **Legally adopted** - Attached proof of legal adoption (i.e. copy of signed court papers).

   (B) **Step-child** - Indicate date you became financially responsible for this child and **attach a copy of your spouse's divorce decree giving them residential custody** or letter from school stating the child's legal address according to their records. If the child is **over 18 years old, please submit a copy of their current driver's license**. If the child has reached **their 19th birthday** but has not yet reached their 25th birthday, **they must be a full-time student at a college, university, military or other accredited facility to be eligible for coverage.** Student proof must be signed by the school registrar or other proof showing full-time status or confirmation of last semester and payment to the school. This must be supplied every spring and fall semester.

   (C) **Age extension** - For a Dependent who has reached his/her 19th birthday and is incapable of self-sustaining employment by reason of mental retardation or physical handicap (and who became so prior to age 19), attach a physician's statement detailing the nature of the disability, the date of occurrence, prognosis for recovery, and physician's opinion regarding dependent's ability to seek and hold gainful employment.

   (D) **Legal guardianship** - Attach copies of legal guardianship letters from the court appointing your legal guardian of this Dependent. A copy of the child's social security card and birth certificate are required.

2. What percentage of the Dependent's support do you provide? _____ %

3. Name other persons and/or agencies providing support and indicate what percentage they provide.

   _____

   (A) Indicate types of coverage provided by source listed above (health, dental, optical, prescription, etc.). _____

   (B) Indicate name and address of other insurance carrier Dependent has other than yours.

   _____

(Continued on reverse side)

4. Does this Dependent reside in your home? ☐ Yes ☐ No

   If yes, give the date when such residence began. _____

   How long do you anticipate such residence will continue? _____

5. Give the reason(s) the Dependent lives with you and is dependent upon you for support.

   _____

   _____

6. Please utilize this area to explain any extenuating circumstances you may have, or to provide further information as to why the Dependent qualifies for coverage.

   _____

   _____

I understand this information is given to the Trustees of the Suffolk County Municipal Employees Benefit Fund for the purpose of inducing the Fund to extend coverage for the above Dependent under the plan of benefits. I understand any false or misleading statement made in order to receive benefits for which my dependent does not qualify will subject me to financial responsibility for any benefits paid and/or other legal actions appropriate to the prosecution of such fraud.

_____ _____

Date Employee's Signature

Failure to provide the proper attachments may result in a denial. The Fund reserves the right to require additional information.

Fund Eligibility Department telephone number: 631-319-4099 ext. 321or email at wendyz@scmebf.org

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivision (b), (e) and (f). Failure to provide this information may result in denial of benefits. This information will be maintained by the Suffolk County Municipal Employee Benefit Fund. This office is responsible for these records and information contained therein may not be released without authorization.

Do not write below this line

For use by the SCME Benefit Fund

☐ Approved Date transaction submitted to add dependent: _____

☐ Disapproved Date documentation submitted: _____

☐ Renewal Date

Date: _____ Signature of Fund Administrator: _____