Statement of Dependence Application
For Coverage of a Custodial Dependent

BY COMPLETING THIS FORM THE MEMBER IS REQUESTING COVERAGE FOR

[ ] Legally Adopted Child [ ] Step-Child [ ] Legal Guardianship

I understand this information is given to the Suffolk County Municipal Employees Benefits Fund for the purpose of inducing the Fund to extend coverage for the below dependent under the plan of benefits. I understand any false or misleading statement made in order to receive benefits for which the subject individual 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.

This Section to be Completed by Fund Member (Please Print or Type)

Member Name | BF# | Social Security Number (Last 4 digits) XXX-XX-_____

Home Address (No. and Street) | Apt# | City | State | Zip

Dependent's Name | Dependent's Date of Birth | Gender ___ Male ___ Female

Dependent Relationship to Member

[ ] Son [ ] Daughter [ ] Other_____

Dependent Marital Status

[ ] Single [ ] Widowed [ ] Married [ ] Divorced

Is the dependent listed above your unmarried child, step-child or adoptive child that has yet to reach the age of 26? [ ] Yes [ ] No

Are you a dual member with the Benefit Fund (married or domestic partner to a county employee)? [ ] Yes [ ] No

Bargaining Unit and union of which they are a member, if applicable [ ] Yes [ ] No

If yes, give name _____

Legally Adopted Child - Please supply legal court papers & skip to section requiring your signature [ ] Papers attached

Please give date approved by the courts _____

Legally Appointed Guardianship - Please supply court papers appointing you legal guardianship [ ] Papers attached

Please give date approved by the courts _____

Step-Child - Proof of each item listed below is required:

A copy of your spouse's divorce decree assigning residential custody [ ] Papers attached

If there is no divorce decree please supply reason in writing [ ] Papers attached

A letter from the child's school stating the child's legal address (under 18) [ ] Papers attached

If the child is ***over the age of 18*** a copy of the child's current driver's license is required [ ] Papers attached

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

Name other persons and/or agencies providing support and indicate what percentage:

_____

_____

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

_____

_____

Indicate name and address of other insurance carrier of benefit plan the dependent has other than yours:

_____

Does the 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? _____

Employee Signature _____ Date _____

FAILURE TO PROVIDE THE PROPER ATTACHMENTS MAY RESULT IN A DENIAL.
THE FUND RESERVES THE RIGHT TO REQUIRE ADDITIONAL INFORMATION.

If you have any questions, please do not hesitate to contact Wendy Z, the Eligibility Coordinator, at: 631-319-4099 ext. 321 or email at Wendyz@scmebf.org

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 Benefit Fund. This office is responsible for these records and information contained therin may not be released without authorization.

This Section To Be Completed by Suffolk County Municipal Employees Benefit Fund

Effective date of ancillary benefits for above dependent: _____

Was previous SOD submitted? [ ] Yes [ ] No Date: _____

Was dependent a late enrollment? [ ] Yes [ ] No

I have reviewed the documentation submitted and verified that the dependent meets eligibility requirements of the Plan.

[ ] Permanently approved [ ] Temporarily approved to _____

Benefit Fund Administrator Signature _____ Date _____

SOD42519

SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

STATEMENT OF DEPENDENCE APPLICATION/RENEWAL AFFIDAVIT

STATE OF)
) ss.:
COUNTY OF)

_____, being duly sworn deposes and says, under
(name of covered member)

penalty of perjury:

That I understand that I will be required to continue to provide proof of said dependency status, on an annual basis for my step-child or legal guardianship child, to the Fund.

DATED: _____, 20___

_____
(signature of covered member)

Sworn to before me this

____ day of _____, 20__.

_____
(Notary Public)

My Commission Expires: _____