Employee Acknowledgment and Signed Declaration:

I attest that my adult dependent being added to the medical plan has no other group medical coverage available to him/her through his/her employer's, spouse's, and/or domestic partner's plan. Should he/she become eligible for other medical coverage, I will notify the Treasurer's Office in writing within 30 days of eligibility of such other coverage by completing a Change Request form to stop this dependent's group coverage.

I understand and accept that any false or misleading statement made, or false or misleading documentation provided, will subject me to disciplinary action up to and including termination of employment and possible charges of fraud and that I will be required to pay back the plan for all previously processed expenses – back to the date of my Adult Dependent's ineligibility.

_____ _____

Employee Signature Date

Adult Dependent Acknowledgment and Singed Declaration:

As an Adult Dependent of a _____ Employee, I declare that I
(School District)
am not eligible for other medical coverage through my employer's plan or my spouse's and/or domestic partner's plan.

_____ _____

Adult Dependent signature Date