

AFFIDAVIT OF GRANDCHILD ELIGIBILITY

The Lee County Benefits Plan provides coverage for a grandchild if the parent is a covered dependent under the Plan when the child is born. The grandchild may remain covered under the Plan for up to 18 months as long as the parent is a Plan Participant and meets the definition of a dependent as defined below:

- 1) Child is unmarried;
- 2) Child is dependent upon the employee for support;
- 3 a) Child is a full or part-time student at an accredited school, college, or university; OR,
b) If not a student, the Child is **residing** with the Employee;
- c) More than 50% of the child's total financial support MUST be provided by the employee;**
- d) If employed, the child MUST NOT be eligible for their own employer-paid benefits.**

The Internal Revenue Service (IRS) has determined that the cost of providing benefits for children who do not meet the IRC Section 152 (as modified by Code 105 (b)) definition of qualified dependents is considered ordinary or "imputed income" and is, therefore, subject to taxes). The taxable amount represents the County's cost of providing benefits for your grandchild.

In order for your grandchild to be considered a qualified dependent, you must be able to establish that you provide more than half the cost of supporting the child. Support involves the cost of shelter, food, clothing, healthcare, transportation and similar necessities. If your grandchild does not meet the support requirement, the child may remain on the plan for 18 months; however, the imputed income provision will apply.

Please complete the following information for your grandchild and return this form to Human Resources - Benefits as soon as possible. ***If this information in a timely manner, we will assume that your grandchild does not meet the qualified dependent criteria and the imputed income provision will apply.*** (Note: Failure to accurately disclose all requested information can result in the termination of you and your dependents from all Lee County Benefits plans.)

Name of Dependent: _____ Social Security # _____

Name of Grandchild: _____ Social Security # _____

By my signature below, I affirm that the above dependent ***is eligible*** to remain covered under the Lee County Health Benefit Plans.

By my signature below, I affirm that the following statement regarding the support of my grandchild is accurate:

I am responsible for at least 50% of my grandchild's financial support.

I am ***not responsible*** for at least 50% of my grandchild's financial support.

Employee Signature: _____ Date: _____

Social Security #: _____