

AFFIDAVIT OF ELIGIBILITY

I, _____, do hereby swear or affirm that I am the legal
(*Employee's Name Here*)

parent of the child noted below who is related to me naturally or through an adoption or
through my marriage or through my legally recognized Domestic Partner:

(*Child's Name Here*)

I further swear or affirm that the child noted above is between the age of 25 and 30 years
old and (circle **ONE** option below):

- *Is unmarried, resides in the State of Florida, does not have any dependent children and is not covered under any other insurance Plan. Copy of FL State DL or FL State ID Card is attached.*

OR

- *Is unmarried, resides in the State of Florida & does not have any dependent children **but** is also a Full Time or Part Time Student at an accredited institution within the contiguous United States and is not covered under any other insurance Plan. Please see the attached evidence of student status.*

I have provided this information for use by the JMH Health Plan for the purpose of determining eligibility for and participation in the JMH Health Plan's HMO/POS (as applicable). I affirm that the information in this Affidavit of Support is true to the best of my knowledge and belief. I understand that any misrepresentation by me in this Affidavit may result in retroactive termination of coverage in JMH Health Plan's HMO/POS (as applicable) and retroactive denial of claims previously processed.

(*Employee's Signature*)

Subscribed and Sworn/Affirmed personally before me, a Notary Public, on the

_____ day of _____, 2___ by _____, who is
(*Employee's Name*)

personally known to me or who has provided satisfactory proof of identification.

Notary Public

My Commission Expires: _____