



**AFFIDAVIT OF OVERAGE DEPENDENT ELIGIBILITY (AGE 26-30)**

Florida Statute 627.6562

**MIAMI-DADE COUNTY EMPLOYEE INFORMATION**

Name: \_\_\_\_\_ Miami-Dade County Employee ID#: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

**DEPENDENT INFORMATION**

Dependent's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Aetna Member ID #: \_\_\_\_\_

**By checking each item below, I hereby certify that the dependent identified above:**

- ☐ Is my child (birth certificate)
- ☐ Is unmarried
- ☐ Has no dependents (children) of his or her own
- ☐ Is a resident of Florida or a full-time/part-time student (Florida Driver's License or School Registration)
- ☐ Does not have other insurance coverage and is not entitled to Medicare
- ☐ Has been continuously covered without a gap of more than 63 days since age 25

**Statement of Non-Eligible Dependent:**

☐ I certify that the dependent identified above is **NOT** an eligible dependent under Florida Statute 627.6562.

I recognize that this affidavit is legally binding and accept full responsibility for notifying Miami-Dade County of any changes.

This form expires 12/31 of the plan year or when the dependent no longer meets eligibility criteria.

**Supporting documentation (proof of FL residency or school registration) must be attached.**

Submit completed affidavit and documents to: **VerifyMyMDCDependent@aetna.com**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SWORN TO and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_

Who is personally known to me ☐ who produced a current driver's license ☐ who produced \_\_\_\_\_ as identification

Notary Public Signature: \_\_\_\_\_ Notary Public Name: \_\_\_\_\_

My commission expires: \_\_\_\_\_