

School Board of Sarasota County FL Dependent Eligibility Review Form

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
<p>A. SPOUSE</p> <p>Legally married spouse, as defined by the State of Florida</p>	<p>Copy of a marriage certificate or acceptably executed marriage license that identifies the couple, date of marriage, legal jurisdiction and has a seal showing it has been properly recorded with the County and/or State. A church ceremony document will not be acceptable if it does not meet these requirements.</p>
<p>B. CHILD – Birth to 26th Birthday</p> <p>Coverage is available for children to include son, daughter, stepson, or stepdaughter of the employee.</p> <p>Child coverage also includes both legally adopted individuals and “eligible foster children” (defined as an individual who is placed with the employee by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.)</p> <p>The child does not have to be a student, dependent upon the parent for support, or living with the parent.</p> <p>The child may be married or unmarried (coverage does not extend to the spouse of the child).</p>	<p>Natural or adopted child of employee – copy of birth certificate or court order. The birth certificate must show parent names.</p> <p>Stepchild of employee – copy of birth certificate of stepchild AND copy of marriage license or most recent joint tax return of employee and the biological parent</p> <p>Foster child, or child placed in legal guardianship of employee or employee’s spouse* – court order or other legal document validating the child’s legal relationship to the employee or to the employee’s spouse*</p> <p>*Must also provide one of the required documents from Category A, SPOUSE</p>
<p>C. CHILD – 26th Birthday to Age 30*</p> <ul style="list-style-type: none"> • Unmarried child between the ages of 26-30* • No dependents of their own • Florida resident (or a full- or part-time student) • Not covered under any other health plan or policy • Not entitled to Social Security or Medicaid benefits <p>*Date child turns 26 through end of the calendar year in which child turns 30</p>	<p>Must provide the same required documentation as in Category B, CHILD</p> <p>Employee must also complete: <i>Statement of Dependent Child Status for Children Aged 26-30 (attached)</i></p>
<p>D. DISABLED CHILD</p> <p>Unmarried child age 26 or over who is incapable of self-sustaining employment by reason of mental or physical disability</p>	<p>Must provide the required documentation of the appropriate age categories listed above AND proof of Social Security Disability Award for the dependent OR physician’s statement to verify that disabled child continues to be incapable of self- sustaining employment by reason of mental or physical disability. This physician’s statement will be required annually.</p>

Please send all documents within 30 days of enrollment to **Risk Management** via mail, pony, fax or e-mail.

Fax: 941-927-4017
e-mail: riskmanagement@sarasotacountychools.net
Mail: 1960 Landings Blvd., Sarasota, FL 34231



SARASOTA COUNTY SCHOOLS

STATEMENT OF DEPENDENT CHILD STATUS FOR CHILDREN AGED 26-30

I, the undersigned, hereby declare the following under penalty of perjury under applicable law:

I, _____, am currently an employee of the School Board of Sarasota County Florida and _____ is my child who desires to be covered as an eligible dependent pursuant to the rules and procedures of the School Board of Sarasota County Group Medical Plan.

I understand that the School Board of Sarasota County Group Medical Plan requires that in order for a child aged 26 to 30 (*defined as the first day of the calendar year in which the child turns 26 through the last day of the calendar year in which the child turns 30*) to be eligible to participate, s/he must meet all of the following qualifications:

- **Is unmarried without dependents of his/her own, and**
- **Is a Florida resident or a full- or part-time student, and**
- **Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.**

As requested, I will provide the required documents to verify I am the parent, stepparent, adoptive parent, foster parent, or legal guardian of the above-named child.

I understand that if I do not provide the School Board of Sarasota County with the required documentation that this benefit coverage may be retroactively cancelled and I will be liable for any claims paid on his or her behalf. In addition, the School Board of Sarasota County, at its discretion, may take other action to receive reimbursement, which may include payroll deductions.

I represent that the information contained herein is true and complete to the best of my knowledge. I understand that in the event that false or misleading information is intentionally furnished to the School Board of Sarasota County or its representatives in connection with this Statement, the School Board of Sarasota County may initiate disciplinary action up to and including termination of employment.

Name of School Board of Sarasota County Employee *[please print]*

Signature of School Board of Sarasota County Employee

Date