

**Allegheny County Certification of Child Status
FOR EACH ELIGIBLE CHILD AGE 19 TO AGE 26**

Employee Last Name, First Name, MI, & Social Security Number

Child's Last Name, First Name, MI, & Social Security Number

Child's Date of Birth: ____/____/____

Relationship (Please circle): Biological Child; Adopted Child; Stepchild; Legal Guardianship
(Children include biological children, adopted children, stepchildren, and children for whom you have legal guardianship as long as you are able to provide the necessary documentation indicated below. The coverage under the Allegheny County plan will be provided effective January 1, 2012. Note that if your child has coverage under his or her own employer's plan, coverage under the Allegheny County group medical plan will not be made available.)

Enroll my child in my (Please circle applicable plan(s)): Medical plan; Dental plan

REQUIRED DOCUMENTS:

- 1.) Certification of Child Status (notarized original required), **AND**
- 2.) Check and provide ONE of the following (EVEN IF PREVIOUSLY PROVIDED):
 - Copy of child's official State birth certificate* (must show employee, retiree or spouse as parent), **OR**
 - Copy of final adoption decree signed by judge (must show employee, retiree or spouse as parent), **OR**
 - Copy of court order confirming the employee/retiree has permanent legal custody.

*For a stepchild, also provide a copy of the official State marriage certificate
- 3.) Allegheny County Highmark Enrollment and United Concordia enrollment form(s) as applicable.

Is your child currently employed (Please circle): YES or NO

If YES, provide your child's employer's name, address and telephone number:

(Additional Information is Required -- Please Refer to Side Two)

Is your child eligible for his or her own employer-sponsored health coverage?
(Please circle): YES or NO

I UNDERSTAND THAT:

ENROLLMENT FOR BENEFITS TO WHICH MY DEPENDENT(S), MY CHILD OR I AM NOT ENTITLED IS CONSIDERED TO BE FRAUD.

IF I WILLFULLY MISREPRESENT THE ELIGIBILITY OF MYSELF OR MY CHILDREN OR DEPENDENTS; FAIL TO TAKE THE NECESSARY ACTION TO REMOVE MYSELF, INELIGIBLE CHILDREN OR DEPENDENTS; OR IN ANY WAY OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED, OR TO WHICH MY CHILDREN OR DEPENDENTS ARE NOT ENTITLED, BENEFITS WILL BE CANCELED. FURTHER, I MAY BE REQUIRED TO REPAY ANY CLAIMS WHICH HAVE BEEN PAID INAPPROPRIATELY, AND I MAY FACE CHARGES AND/OR DISMISSAL FROM MY EMPLOYMENT WITH ALLEGHENY COUNTY.

ALLEGHENY COUNTY RESERVES THE RIGHT TO REQUEST ADDITIONAL DOCUMENTATION.

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, and belief.

Signature of Member Employee/ Retiree: _____

Date: _____

Subscribed and sworn to before me this _____ day of _____, 20_____

Notary Public: _____

Date my Commission Expires: _____

Notarize and return to: Allegheny County Department of Human Resources
542 Forbes Avenue, County Office Building, Room 102
Pittsburgh, PA 15219
Attn: Employee Benefits