



**STATE EMPLOYEE HEALTH PLAN (SEHP)
DEPENDENT CHILD AFFIDAVIT**

1. Member and Dependent Information		
Member's Name <small>(LAST, FIRST, MI)</small>	Member's Employee ID or Social Security Number	Member's Phone Number <small>Including Area Code</small>
Dependent Child Name <small>(LAST, FIRST, MI)</small>	Dependent Child's Social Security Number	Dependent Child's Date of Birth

Does the dependent child reside with you for more than 6 months of the year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do both the dependent child and member reside in the member's home? If not, please list the dependent child's address: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you provide greater than 50% of the dependent child's support?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you claim the dependent on your most recent federal income tax return?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the dependent child file a federal tax return in the most recent tax year? If yes, please include a copy of pages 1-2 of federal forms 1040 or 1040A showing the dependent child's name and signature.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the dependent child a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico at some time during the tax year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have legal custody, or have you adopted the dependent child? If yes, date of legal custody or adoption: _____ If yes, please include a copy of the first and last page of the legal custody or adoption document.	Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby certify that the above listed information is true and correct. I agree that I will notify the SEHP of any changes in this information.

Member's Signature	Date
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The member's signature must be notarized.

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

_____ My commission expires _____, 20_____.

Notary Public

(SEAL)