



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

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

Does the grandchild reside with you for more than 6 months of the year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do both the grandchild and parent reside in the member's home?  If not, please list their address: _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you provide more than half of the grandchild's support?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the grandchild 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 your grandchild?  If <b>yes</b> , date of legal custody or adoption: _____  If <b>yes</b> , 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 within 30 days of the change.

<b>Member's Signature</b>	<b>Date</b>
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**The member's signature must be notarized.**

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

\_\_\_\_\_  
Notary Public My commission expires \_\_\_\_\_, 20\_\_\_\_\_.

(SEAL)