Town of Norton

Subscriber Affidavit for Dependent Eligibility for Health Insurance

Please print

Subscriber Name: _____

Address: _____ _____

Town/City: _____ State: _____ Zip Code: _____

Best Contact Number: _____

Email Address: _____

Dependent Spouse or Former Spouse:

Name: _____ Date of Birth: _____

Address (If different than above): _____

_____

Are you currently legally married to this dependent? YES / NO

- If YES, Date of Marriage: _____
- If NO, Date of Divorce: _____
  - Are you remarried? YES / NO If Yes, Date of remarriage: _____
  - Is your former spouse remarried? YES / NO / Unknown If YES, Date of marriage: _____

Other Dependents:

1. Name: _____ Relationship to Subscriber: _____
   Date of Birth: _____ SS #_____
2. Name: _____Relationship to Subscriber: _____
   Date of Birth: _____ SS #_____
3. Name: _____Relationship to Subscriber: _____
   Date of Birth: _____ SS #_____
4. Name: _____Relationship to Subscriber: _____
   Date of Birth: _____ SS #_____

Please initial each after reading:

_____I hereby certify that the information provided above is true and accurate.

_____I certify that the dependents named about are eligible for coverage under my health insurance plan.

_____I understand that I am obligated to inform my employer immediately if there are any changes in my status or that of my dependents.

_____ I understand that any misrepresentation in the information given may result in termination of benefit eligibility for myself and/or my dependents, and that I may be held responsible for claims incurred after date of ineligibility.

_____ _____

Subscriber Signature Date