Affidavit of Dependent Eligibility

Required for Retirees Adding or Continuing Coverage of Eligible Dependents Age 19 Up to Age 26
(or Age 26 and Older if Dependent Incapacitated)

Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612
510-628-3000 or 1-800-838-1932, Press 1 www.acera.org

Retiree Name: _____ Retiree's last 4 digits Social Security #: XXX-XX- _____

Daytime Telephone Number: _____

Who Should Submit This Form

A. ACERA Members Newly Enrolling a Dependent | You are required to submit this form if you are electing coverage for new eligible dependents age 19 up to age 26 or dependents age 26 and older if incapable of supporting themselves due to a mental or physical disability incurred prior to age 26 (must provide proof of dependent's incapacity prior to age 26; contact ACERA). See ACERA's 2017 Retiree Enrollment Guide for dependent eligibility requirements. Failure to submit these documents will waive the enrollment of your dependent for the 2017 plan year. You are required to provide supporting documentation along with this form to ACERA:

Provide ACERA One of the Following Documents Along With This Form:

- Certified copy of birth certificate
- Original church baptismal certificate with mother/father listed
- Court-filed guardianship/adoption papers

B. ACERA Members Who Are Continuing Coverage for a Dependent | You are required to submit this form if you are electing to continue coverage for existing eligible dependents. Failure to submit this form will waive the enrollment of your dependent for the 2017 plan year, even if your dependent is a current participant.

Instructions for Completing This Form

Step 1: On the reverse side of this form, list **ALL** current and newly enrolled dependents.
Important Note: This form **DOES NOT** replace the medical, dental, and/or vision enrollment forms for new dependents. You must complete the applicable enrollment forms in addition to completing this form.

Step 2: Attach required supporting documentation for all **NEW** dependents listed on the reverse side of this form. **Failure to do so will result in either non-enrollment of your dependent or loss of coverage for your dependent(s).**

Step 3: Sign, date, and return this form along with the required supporting documentation to:

ACERA
475 14th Street, Suite 1000
Oakland, CA 94612

Affidavit of Dependent Eligibility Certification

List all current and newly enrolled dependents in the spaces below. For additional dependents, use a separate sheet.

Dependent Name	MI	Dependent Enrollment Status (Mark One)	Date of Birth	Social Security Number	Check each healthcare plan the dependent(s) is to be enrolled:
Last Name First Name		☐ Currently Enrolled ☐ Newly Enrolling			☐ Medical ☐ Dental ☐ Vision
Last Name First Name		☐ Currently Enrolled ☐ Newly Enrolling			☐ Medical ☐ Dental ☐ Vision
Last Name First Name		☐ Currently Enrolled ☐ Newly Enrolling			☐ Medical ☐ Dental ☐ Vision
Last Name First Name		☐ Currently Enrolled ☐ Newly Enrolling			☐ Medical ☐ Dental ☐ Vision
Last Name First Name		☐ Currently Enrolled ☐ Newly Enrolling			☐ Medical ☐ Dental ☐ Vision

Retiree Certification:

I understand that my child is eligible for coverage under ACERA's medical, dental, and/or vision plan (Healthcare Plan) if I am currently enrolled in said plan and he or she is not eligible to enroll in an employer-sponsored health plan offered by his or her own employer or the employer of his or her spouse. I also understand that my child is only eligible to be enrolled in this Healthcare Plan until either I am no longer enrolled in said plan or the end of the month that includes his or her 26^{th} birthday (unless incapacitated prior to age 26).

I certify that the information I have provided on this Affidavit of Dependent Eligibility form about my child is true and complete under penalty and perjury. I understand any false information or statements I provide on this Form will be grounds for ACERA among other things to rescind my Healthcare Plan coverage and my dependent's Healthcare Plan coverage.

I certify each child I have enrolled meets the conditions for enrollment in the Healthcare Plan and each child:

- Will not reach his or her 26^{th} birthday prior to the effective date of coverage (February 1, 2017) (unless incapacitated prior to age 26) and,
- Is not eligible for enrollment in a Healthcare Plan maintained by his or her own employer or the employer of their spouse.

Retiree Signature: ____ Date: ______________