

# City of Miami



## AFFIDAVIT OF ELIGIBILITY

I, \_\_\_\_\_, hereby swear or affirm that I am the legal parent of the child(ren) noted below who is related to me naturally or through an adoption or through my marriage:

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Child's name

I further swear or affirm that the Child(ren) noted above is (are) between the ages of 25 and 30 years old and (check one option below):

- Is unmarried and does not have a dependent of his/her own and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other insurance plan. Attached is a copy of the Child's State of Florida Driver's License or Identification card.

OR

- Is unmarried and does not have a dependent of his/her own and is a resident of Florida or a full-time or part-time student and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other insurance plan. Please see the attached evidence of student status

I have provided this information for use by the City of Miami's group healthcare plans for the purpose of determining eligibility and participation in the City of Miami's group healthcare plans (as applicable).

I affirm that the information in this Affidavit of Eligibility is true to the best of my knowledge and belief. I understand that any misrepresentation by me in this Affidavit may result in retroactive termination of coverage in the City of Miami group healthcare plans and retroactive denial of claims previously processed.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.**

\_\_\_\_\_  
Employee's/Subscriber's Signature

Subscribed and Sworn/Affirmed personally before me, a Notary Public, on this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_ by \_\_\_\_\_, who is personally known to me or who has provided satisfactory proof of identification.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

Indicate your employee group  
 AFSCME     MG/CONF  
 EXECUTIVE     UNCLASSIFIED  
 FIRE     SEA  
 ACTIVE EMPLOYEE     RETIREE

For City Use Only  
Coverage Eff. Date \_\_\_\_\_  
Pay Period \_\_\_\_\_  
Ded. Code \_\_\_\_\_

**CITY OF MIAMI  
GROUP INSURANCE  
ENROLLMENT/CHANGE FORM  
DEPENDENT AGE 25 TO 30**

**Action Requested**

Open Enrollment     Add Dependent     Cancel Dependent

**Employee Information**

Employee Name: \_\_\_\_\_  
Social Sec. Number: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
County: \_\_\_\_\_

**List dependents to be enrolled – age 25 to 30. Enter Primary Care Physician you choose**

Dependent Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Sex: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
PCP Name and ID#: \_\_\_\_\_

Dependent Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Sex: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
PCP Name and ID#: \_\_\_\_\_

**Employee Post Tax Election**

I authorize the City of Miami to convert a portion of my salary to pay the contribution I would otherwise be required to make towards the City's health care coverage on An after-tax basis for the above listed dependent(s). I understand that I may not change my payroll deduction elections during the plan year except as allowed by Internal Revenue guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CIGNA'S Authorization Clause**

The information provided above is true and correct to the best of my knowledge. I also authorize release to or by CIGNA or to their representative, and hospital, medical or other insurance information concerning myself or any of my dependents which may be required to process my claim, or to administer an insurance case management survey for subrogation purposes, or coordination of benefits. I understand that the participating providers, if any, do not necessarily include all types of doctors or providers. I authorize payment of benefits to the participating provider of the benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_