



AFFIDAVIT OF DEPENDENCY Health Benefits Program

To enable the County of Monmouth to determine the eligibility of the dependent child (ren) listed on my Health Benefits application of coverage in the Monmouth County Program, I state the following with respect to the child (ren) listed below.

Employee Name : _____ MC Employee ID #: _____
 Department: _____ Work phone: _____

RELATIONSHIP (check one)	RESIDENCE (check one)	FINANCIAL SUPPORT (check one)
<input type="checkbox"/> My child(ren)	<input type="checkbox"/> Live(s) with me	<input type="checkbox"/> Substantially dependent on me for support and maintenance
<input type="checkbox"/> My stepchild(ren)	<input type="checkbox"/> Do(es) not live with me	<input type="checkbox"/> Not substantially dependent on me for support and maintenance
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Name (s) of Child(ren) Last Name	First Name	Date of Birth Month-date-year	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I certify that the statement and information submitted above is correct.

 Print Full Name _____
 Date

 Address

 Signature (must be the same name as printed above)

State of _____ County of _____

Sworn and subscribed before me this _____ of _____

My Commission expires _____

Signature of Notary Public _____

Official Title _____