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 :_____ **Social Security:**_____

Department:_____ **Work phone:**_____

RELATIONSHIP (check one)	RESIDENCE (check one)	FINANCIAL SUPPORT (check one)
☐ My child(ren)	☐ Live(s) with me	☐ Substantially dependent on me for support and maintenance
☐ My stepchild(ren)	☐ Do(es) not live with me	☐ Not substantially dependent on me for support and maintenance
☐ Other _____	☐ 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 _____