



STATE OF RHODE ISLAND
Department of Administration
Office of Employee Benefits
One Capitol Hill
Providence, RI 02908-5860
Office: (401) 222-3160
Fax: (401) 222-2964

AFFIDAVIT OF ELIGIBILITY FOR CHILDREN UNDER AGE 26

Employee Name

Child's Name

Employee Work Telephone Number

Child's Place of Employment

Employee Medical ID #: _____

I hereby certify that my child listed above is not eligible for an employer group medical plan through his/her employment.

I have attached a copy of my child's birth certificate and a completed Health Insurance Enrollment Form in order to complete the enrollment process for adding my child to my medical insurance policy.

I understand that the information contained in this Affidavit is being provided for the sole purpose of determining eligibility for benefits.

I affirm that the statements attested to in this Affidavit are true and correct to the best of my knowledge. I understand that misrepresentation of information in this Affidavit will result in my obligation to repay any benefits received.

Employee Signature

Date

State Dept/Agency

OEB Approval _____

Date: _____