STATE OF MARYLAND AFFIDAVIT of STATUS FOR DEPENDENT CHILDREN

Name of Employee/Retiree: _____
Last First M.I.

Employee's/Retiree's Social Security Number: _____

Name of Dependent (hereafter, "Dependent" or "Child"): _____
Last First M.I.

Dependent's Date of Birth: _____ Social Security Number: _____

PART I.	
A. Initial the box for the statement below that describes your relationship to the Dependent and go to Section B. If none apply, this person is NOT an eligible dependent and cannot be added to your health benefits coverage.	
	The Dependent is my biological child.
	The Dependent is my adopted child OR a child placed with me for adoption by me.
	The Dependent is my stepchild.
	The Dependent is my grandchild.
	The Dependent is my step-grandchild.
	The Dependent permanently resides with me and I am his/her testamentary or court appointed guardian for a non-temporary guardianship of not less than 12 months.
	The Dependent is related to me by blood and/or marriage, permanently resides with me and I provide his/her sole support.
B. If the Dependent is **not** married, initial the box below and go to Section C. If the Dependent is married, he/she is NOT an eligible dependent and cannot be added to your health benefits coverage.	
	The Dependent is **not** married.
C. Initial the box for the statement below that describes the Dependent and go to PART II. If neither statement describes the Dependent, this person is NOT an eligible dependent and cannot be added to your health benefits coverage.	
	The Dependent is under the age of 25.
	The Dependent is any age and is incapable of self-support because of a mental or physical incapacity incurred before reaching age 25 and is chiefly dependent on me for support.

AND

PART II. The Dependent must meet all tax criteria for either Qualifying Child **OR** Qualifying Relative. Initial the box for each criteria that is true for this Dependent. **If you cannot initial all four Qualifying Child OR all three Qualifying Relative criteria, this person is NOT an eligible dependent and cannot be added to your health benefits coverage.**

Qualifying Child Test: Initial each criteria that applies to the Dependent - **must meet all four**	
1	The child is my biological child or adopted child (or placed for adoption by me), my legal ward or child placed with me under court order (not temporary for less then 12 months), my step-child, sibling, or a descendent of my child or sibling (i.e. my grandchild, niece, nephew, etc.); **and**
2	The child lives with me for more than half of the year (more than six months) **or is my biological or adopted child and meets the following residence exception:** ►The child receives over half of the child's support during the calendar year from the child's parents, who **(1)** are divorced or legally separated under a decree of divorce or separate maintenance, **or** (**2)** are separated under a written separation agreement, **or (3)** live apart at all times during the last six months of the calendar year; **and** ►The child is in the custody of one or both of the child's parents for more than half of the calendar year; **and**
3	The child **(1)** has not attained age 19 as of the close of the calendar year(s) in which coverage is provided, **or (2)** is a full-time student for at least five months of the calendar year who has not attained age 24 as of the end of the calendar year(s) in which coverage is provided, **or (3)** is permanently and totally disabled; **and**
4	The child has not provided more than half of the child's own support for the calendar year(s) in which coverage is provided.
OR	
Qualifying Relative Test: Initial each criteria that applies to the Dependent - **must meet all three**	
1	The Dependent has a specified relationship to me: my biological child, my adopted child (or placed for adoption by me), my step-child, my grandchild, my niece, my nephew, my sibling, or a person who is not my lawful spouse who lives with me and is a member of my household for the entire year (this includes a legal ward); **and**
2	I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided; **and**
3	The Dependent is **not my or anyone else's qualifying child** for the tax year(s) in which coverage is provided. I*f this child meets all four tax criteria for the Qualifying Child Test, this statement is not true.*

I solemnly affirm under the penalties of perjury that the contents of this paper are true regarding the Dependent to the best of my knowledge, information and belief. Refer to the reverse side for the required Dependent Documentation to confirm the information above.

Employee's/Retiree's Signature:_____Date:_____

DEPENDENT DOCUMENTATION

Employee's/Retiree's Name:_____ Dependent's Name:_____

Refer to the list below for the documentation required to confirm the eligibility of the Dependent listed above. Write your initials in the appropriate box(es) below to indicate the documents attached to this form. Submit the Affidavit and documents along with your Enrollment Form to your Agency Benefits Coordinator (for Active/Satellite Employees) or to the Employee Benefits Division (for Retirees/Beneficiaries and Direct Pay Enrollees).

Biological Child	
	Copy of Child's Official State Birth Certificate

Adopted Child (or a child placed with you for adoption by you)	
	Copy of Adoption papers required; must indicate child's date of birth (see Benefits Book for more information regarding pending adoptions)

Stepchild	
	Copy of Child's Official State Birth Certificate (must name spouse of employee/retiree as the child's parent)
	Copy of Employee's/Retiree's Official State Marriage Certificate

Grandchild (for Step-Grandchild , see Other Child Relative below)	
	Copy of Child's Official State Birth Certificate
	Copy of Child's Parent's Birth Certificate (to document grandchild's relationship to the employee/retiree)

Legal Ward, Testamentary or Court appointed guardianship (not temporary for less than 12 months)	
	Copy of Dependent's Official State Birth Certificate
	Proof of Permanent Residency; see acceptable documents noted below: Valid Driver's License or State-issued Identification Card, school records certifying Dependent's address, day care records certifying Dependent's address, Tax Documents certifying address with child's name listed on Tax Document.
	Copy of Legal Ward/Testamentary Court Document, signed by a Judge

Other Child Relative (includes step-grandchildren)	
	Copy of Child's Official State Birth Certificate
	Proof of Permanent Residency; see acceptable documents noted below: Valid Driver's License or State-issued Identification Card, school records certifying Dependent's address, day care records certifying Dependent's address, Tax Documents certifying address with child's name listed on Tax Document.
	Sole Support Affirmation: I certify by my signature below that the dependent child listed on the reverse side of this form is supported solely by me. _____ Employee's/Retiree's Signature _____ Date

Disabled Adult Child	
	Disability Certification Form (in addition to applicable documentation listed above)