



HUMAN RESOURCES DEPARTMENT – BENEFITS

2025 ADULT CHILD DEPENDENT(S) (AGES 26 – 30) CERTIFICATION

Rev: 1 | Date: 10/23/2024 | Print Date: 10/30/2024

Employees who want to include an adult dependent child(ren) under their medical coverage must complete and submit this form to the Benefits Section, HR. Submit form and documentation as soon as available to: healthyliving@fortlauderdale.gov or FAX: 954-828-5328.

1. Employee Data (please print):		
LAST NAME	FIRST NAME	EMPLOYEE ID NUMBER

2. ADULT CHILD DEPENDENT(S) INFORMATION: If you have any additional children to add or delete, mark here and list on a separate sheet. A copy of the birth certificate is required.

LAST NAME	FIRST NAME	SOCIAL SEC #	DOB: MM/DD/YYYY	SEX: M/F
Adult Child 1:				
Adult Child 2:				

The City of Fort Lauderdale Benefit Plans allow medical coverage for an adult child dependent from the end of the calendar year in which he/she turns age 26 through the end of the year in which he/she turns age 30; if all criteria below are met.

1. Is unmarried; and
2. Has no dependents of his/her own (i.e. children, domestic partner, etc.); and
3. He/she is dependent on City of Fort Lauderdale employee ("you") for financial support; and
4. Is not provided coverage or covered under any other group or individual health benefit plan; and
5. Is not entitled to benefits under Title XVIII of the Social Security Act; and
6. Is a resident of Florida or is a full or part-time student.

If dependent was not previously covered under your benefit plans, dependent must have been continuously covered by other creditable coverage without a gap in insurance exceeding sixty-three (63) days after the end of the year in which he/she reached age 26. Proof of creditable coverage must be submitted at time of enrollment.

Does the dependent meet Criteria 1 through 6 as listed above? Yes No

Will the dependent be a financial or student dependent in 2025? Financial Student

Financial Dependent Documentation: Please submit this Affidavit and a copy of the dependent's Florida driver's license or state-issued identification showing a valid Florida address.

Student Documentation: Please submit this Affidavit and current school schedule. (Proof of student status must include the following, preprinted by the educational institution: 1) Name of educational institution; 2) Name of dependent; 3) Date of semester showing enrollment for 2025.

EMPLOYEE ACKNOWLEDGEMENT

I have read the rules pertaining to coverage for Over Age Dependents and understand that the portion of the premium attributable to my Over-Age Dependent cannot be deducted pre-tax; and that I will pay imputed income tax on the portion of the subsidy attributable to his/her coverage. Additionally, Over-Age Dependents are not eligible to receive reimbursement from a Health Reimbursement Account (HRA). Employees will not receive the portion of the HRA attributable to coverage of an Over-Age Dependent.

I acknowledge that I have provided true and official documentation; and that the dependent listed above meets the eligibility criteria, as specified by The City of Fort Lauderdale. If a post audit of the enrolled dependent shows that he/she does not meet the eligibility requirements of the plan, I understand that I will be held legally and financially responsible for the repayment of all benefit claims incurred by my ineligible dependent. Florida Statute 817.234 clearly states that any person who knowingly and with the 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 of the third degree. Any person committing such fraud will be subject to appropriate action by Broward County and/or the insurance carrier.

4. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREE TO THE STATEMENTS ON THIS FORM.	
Employee's Signature	Date

For questions, please contact Benefits Section, HR at 954-828-5160.