WORCESTER COUNTY BOARD OF EDUCATION

Sworn Affidavit of Eligibility for Coverage
in the County Medical Benefits Program

Please complete one Affidavit

EMPLOYEE INFORMATION			
Last Name / First Name / MI			Social Security Number
Street Address			Employment Date (MM/DD/YYYY)
City	State	Zip Code	Sex ☐ F ☐ M
Date of Birth (MM/DD/YYYY)	Date of Marriage (MM/DD/YYYY)	Home Phone Number	Department Phone Number

DEPENDENT INFORMATION						
Add or Change	Dependent	Last Name	First Name	MI	Sex	Date of Birth	Social Security Number
	Spouse						
	Child						
	Child						
	Child						
	Child						
	Child						
	Child						

I have attached the following additional documentation (*that applies*) to this Sworn Affidavit:

☐ Marriage Certificate
☐ Birth Certificate (for each dependent)
☐ Adoption Papers
☐ Proof of Legal Guardianship

Certification Statement

I certify and swear that the dependents listed above are mine and are eligible for coverage under the insurance plans. I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true to the best of my knowledge, information, and belief.

_____ _____

Signature of Employee *Date*

Revised 11/13/2013