

Suffolk University Certification of Child Status

FOR EACH ELIGIBLE CHILD AGE 19 TO AGE 26

Employee Last Name, First Name, MI

Child's Last Name, First Name, MI

Child's Date of Birth: ____ / ____ / ____

Relationship: Biological child Adopted child Stepchild Legal guardianship
(Children include biological children, adopted children, stepchildren, and children for whom you have legal guardianship.. The coverage under the Suffolk University plan will be provided effective January 1, 2011.

Enroll my child in my: Health Plan Dental plan

I certify that the child listed above is my child and that all the information provided is correct.

I understand that:

Enrollment for benefits to which my dependents, my children or I am not entitled is considered fraud.

If I willfully misrepresent the eligibility of myself or my children or dependents, fail to take the necessary action to remove ineligible children or dependents, or in any way obtain benefits to which my children or dependents are not entitled, my benefits will be canceled. I will be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from Suffolk University.

Suffolk University reserves the right to request additional documentation.

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, and belief.

Signature of Employee and Date