



**STATE EMPLOYEE HEALTH PLAN (SEHP)
DEPENDENT GRANDCHILD AFFIDAVIT**

Member and Grandchild Information		
Member's Name <small>(LAST, FIRST, MI)</small>	Member's Employee ID or Social Security Number	Member's Phone Number <small>Including Area Code</small>
Grandchild's Name <small>(LAST, FIRST, MI)</small>	Grandchild's Social Security Number	Grandchild's Date of Birth
Grandchild's Parent's Name <small>(LAST, FIRST, MI)</small>	Grandchild's Parent's Date of Birth	Phone Number <small>Including Area Code</small>

Is the grandchild's parent currently enrolled as a dependent under your SEHP coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the grandchild's primary residence the same as your primary residence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you provide more than half of the grandchild's support?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have legal custody, or have you adopted your grandchild? If yes, date of legal custody or adoption: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please include a copy of the first and last page of the legal custody or adoption document.	
Was the grandchild a U.S. citizen, a U.S. national, or a legal resident of the U.S., Canada or Mexico at some time during the tax year?	Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby certify that the above listed information is true and correct. I agree that I will notify the SEHP of any changes in this information within 30 days of the change.

Member's Signature	Date
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The member's signature must be notarized.

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary Public My commission expires _____, 20____.

(SEAL)