ONE CITY. ONE JACKSONVILLE.

City of Jacksonville, Florida

Lenny Curry, Mayor

Compensation & Benefits
City Hall, 117 West Duval St., Suite 150
Jacksonville, Florida 32202
Phone: (904) 630-1314 Fax: (904) 630-1294

2018 OVER-AGE (AGE 26-30) DEPENDENT AFFIDAVIT
PRE-TAX SECTION 125 PLANS
FLORIDA STATUTE §627.6562

Employee Name _____ **Employee ID#** _____

The City of Jacksonville Group Health Plan (the "Plan") allows medical coverage for dependents from the age of 26 through the end of the year in which they turn 30 ("Over-Age Dependent") if the Over-Age Dependent meets **all** of the following eligibility criteria:

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

Name of Dependent (Complete a separate form for each Over-Age Dependent)	Dependent's Age and Date of Birth	Meets the Eligibility Criteria Listed Above	Will Dependent be a Student or Financial Dependent in 2018?
		☐ Yes ☐ No	☐ Student (Submit Over-Age Dependent Affidavit and 2018 school schedule listing educational institution, Dependent name and date showing enrollment) ☐ Financial Dependent (Submit Over-Age Dependent Affidavit and copy of Dependent's Florida License or State issued I.D. documenting he/she lives in the State of Florida)

Tax Disclosure: I UNDERSTAND THAT I WILL BE TAXED ON APPLICABLE IMPUTED INCOME FROM PREMIUMS PAID BY THE CITY OF JACKSONVILLE ON BEHALF OF MY OVER-AGE DEPENDENT WHO IS AGE 27 AND ABOVE AND THAT I WILL NOT BE ELIGIBLE TO PAY HEALTH CARE PREMIUMS ON A PRE-TAX BASIS IF THE DEPENDENT NAMED ABOVE DOES NOT QUALIFY AS MY FEDERALTAX DEPENDENT

DEPENDENT LISTED ABOVE QUALIFIES AS MY FEDERAL TAX DEPENDENT: ☐ **YES** ☐ **NO**

Employee Statement: I acknowledge that I have provided true and official documentation and I certify that the Over-Age Dependent listed above meets the eligibility criteria, as specified by the City of Jacksonville. If a post audit of the enrolled Over-Age 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 Over-Age Dependent. Florida Statute §817.234 clearly states "**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 the City of Jacksonville.

Employee Signature: _____ Date: _____

Complete and return this form and the required documents to:
City of Jacksonville Compensation & Benefits Office