



Grandchild Affidavit

- Office Use Only -	
Approved by _____	Date _____
Effective Date _____	

Use this form ONLY to add coverage for a grandchild who is an eligible dependent child of you, your spouse's or your domestic partner's. You must certify the grandchild meets one of two eligibility criteria in Section 1. For more information: www.oregon.gov/DAS/PEBB/SPD.shtml

- **Open Enrollment:** You may enroll the child electronically; however, the enrollment will not take effect unless you submit this affidavit and required legal documentation to your agency within the allowed time.
- **Newly Eligible Employees, Newly Hired Employees, and Active Employees requesting a midyear change:** You must submit the enrollment or Midyear Change form, this affidavit, and required documentation to your agency within the allowed time, or the agency will not enroll the child for coverage.

Submit completed affidavit and required documentation to your agency payroll or university benefits office. Use one affidavit per grandchild.

1. Your Certification (you must check one)

<input type="checkbox"/> I certify that the child is a biological child of an eligible dependent child and meets the following criteria: <ul style="list-style-type: none"> • The child's parent will not be older than age 26 on December 31, and is unmarried and without a domestic partner • Both the child and parent live in my household and receive over half of their financial support from me Name of biological parent who is your eligible dependent: _____ Date the grandchild and eligible dependent came to live with you: _____	<input type="checkbox"/> I certify that the child is a biological grandchild and meets the following criteria: <ul style="list-style-type: none"> • The child is age 18 or younger and lives in my household. • I am legally responsible for the child's welfare per the attached documentation of guardianship, conservatorship or other legal custody. Date of initial legal responsibility: _____ Date legal responsibility ends: _____
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2. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID
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Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M	
PEBB and the plans in which you enroll will send all benefit-related correspondence to your contact address.					
Contact Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail	(optional)	
Date of Birth (mm/dd/yyyy)	Work Phone	Home Phone	(optional)		

3. Dependent Grandchild Information

Last Name	First Name	M.I.
Relationship to you		Date of Birth (mm/dd/yyyy)
<p>You must submit a midyear change form to your agency within 30 days of the date when an individual you provide coverage to is no longer PEBB eligible. Individuals will be removed prospectively from coverage the last day of the month in which the agency receives the midyear change form from the employee. The exception to prospective removal from coverage is when an ex spouse, ex domestic partner or any child becomes ineligible for coverage because of divorce or dissolution of partnership. In this exception, the ineligible individuals will be removed from coverage the last day of the month in which the divorce or dissolution occurred. Late submission may affect your income taxes. In the case of retroactive terminations, you may be responsible for claims paid for the individual during the period of ineligibility. If you do not report changes of eligibility that occur before open enrollment, you may face civil or criminal charges for fraud, and PEBB may rescind coverage.</p>		

4. Employee Signature and Authorization

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

I understand that:

- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines
- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

I also understand that if I fail to report on required forms a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This affidavit supersedes all forms and submissions I previously made for PEBB coverage for the individual named on this affidavit. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

I certify under penalty of the State of Oregon laws that the foregoing is true and accurate to the best of my knowledge.

Employee Signature _____
Date

State of _____, County of _____

Sworn and Subscribed before me this _____ day of _____ 20_____

Signature of Notary Public: _____

Official Title: _____

Submit completed form to your agency payroll or university benefits office.