EPISCOPAL CHURCH MEDICAL TRUST

# Child Affidavit

This form must be used if you want to enroll your Child for coverage outside of the initial or annual Open Enrollment period, for example, as a result of a Significant Life Event. In order to determine whether your Child meets the eligibility requirements for coverage under your Participating Group's health Plan, this form must be completed, signed, and returned to the Episcopal Church Medical Trust.

**SUBSCRIBER INFORMATION**

Name: ______________________________ SSN ____________________

Address: ______________________________________________________

**CHILD ELIGIBILITY**

In order to be eligible for coverage under your benefits, a Child must meet all of the following requirements:

1. The Child is the Subscriber's: *(CHECK ONE)*

   - ☐ Natural Child
   - ☐ Foster Child (an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order or any court of competent jurisdiction)
   - ☐ Legally Adopted Child
   - ☐ Child placed with Subscriber for Adoption
   - ☐ Disabled Child
   - ☐ Spouse's Child
   - ☐ Domestic Partner's Child (only applicable where Domestic Partnership benefits are offered by the Participating Group)

2. The Child does not have health coverage under another group health plan, and

3. The Child is 30 years of age or younger or is Disabled and the disability began before the age of 25.

**CHILD INFORMATION**

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name: ______________________________ D.O.B.: ____________ Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

**CERTIFICATION**

I certify under the penalty of perjury that the information provided above is correct to the best of my knowledge and that the Children listed on this form fully meet the listed definition of eligibility. I agree to provide proof of my Child relationship upon request by my Participating Group or Plan and agree to notify my Participating Group immediately if there is a change in the status of any Child listed above. I have reviewed the benefit enrollment materials and agree to the terms and conditions listed there.

______________________________ ______________

Subscriber's Signature Date Signed

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RETURN THIS COMPLETED FORM TO:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
Fax: (212) 592-4234
Email: mtcustserv@cpg.org