North American Division of SDA
Health Care Assistance Plan (“HCAP”)
CERTIFICATION FORM

OTHER EMPLOYER-SPONSORED COVERAGE FOR CHILDREN AGE 19 OR OLDER

Children age 19 or over are not eligible to participate in the HCAP if they have access to health coverage through their own employer or the employer of their spouse (if married).

This form must be filled out and signed annually for each child age 19 or over enrolled in the HCAP in order to certify eligibility.

Name of Employee:_______________________________________EE’s SSN:______________________

Name of Employee’s Child: ____

Child’s Date of Birth: ______________________________Child’s SSN: ________________________

Please answer the following questions for the child named above:

1. **Is the child currently employed?**
   - □ No (*please proceed to question 4*)
   - □ Yes (*please proceed to question 2*)

2. **Does the child have access to health coverage through his or her employer?**
   - □ No (*please proceed to question 3*)
   - □ Yes (*if the child has access to health coverage through their employer, the child is not eligible for coverage through the HCAP*)

3. **Please provide the child’s employer and the name and telephone number of a contact person at the child’s employer who can verify the child’s lack of access to health coverage:**

   Employer Name: ____
   Name of Contact Person: ____
   Contact Person’s Telephone Number: ____

4. **Is the child currently married?**
   - □ No (*please proceed to the certification*)
   - □ Yes (*please continue to question 5*)

5. **Does the child have access to health coverage through their spouse’s employer?**
   - □ No (*please proceed to question 6*)
   - □ Yes (*if the child has access to health coverage through their spouse’s employer, the child is not eligible for coverage through the HCAP*)

6. **Please provide the employer of the child’s spouse and the name and telephone number of a contact person at the spouse’s employer who can verify the child’s lack of access to health coverage:**

   Employer Name: ____
   Name of Contact Person: ____
   Contact Person’s Telephone Number: ____

Certification of Employee

I certify the foregoing is true and correct to the best of my knowledge.

I agree to notify my employer immediately if there is any change in the circumstances attested to in this declaration.

I understand that willful falsification of information on this declaration constitutes fraud on the HCAP and may lead to disciplinary action, up to and including termination of benefits under the HCAP and/or termination of employment.

Employee Signature: ____ **Date**: ____________________

Certification and Authorization of Child

I certify the foregoing is true and correct to the best of my knowledge.

I agree to notify my parent's employer immediately if there is any change in the circumstances attested to in this declaration.

I understand that willful falsification of information on this declaration constitutes fraud on the HCAP and may lead to disciplinary action, up to and including termination of benefits under the HCAP.

I authorize my employer and my spouse's employer to release any information regarding my eligibility for health coverage through my employer or my spouse's employer.

Child Signature: ____ **Date**: ____________________