



**PASSHE ACTIVE EMPLOYEE HEALTHCARE PLAN  
ADULT CHILD ATTESTATION FORM  
For children age 19-26**

**Employee Information (Please Print)**

1. Personnel #: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
3. Work Phone Number: \_\_\_\_\_

**Child's Information (Please Print)**

1. Child's date of birth: \_\_\_\_\_
2. Child's Name: \_\_\_\_\_
3. Is the Child's address the same as the employee? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Child's address, if different from the employee:  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Additional Information Required**

1. Provide the name of the child's employer, if applicable: \_\_\_\_\_
2. Is the child **eligible for** other employer-sponsored health coverage (other than through a parent)? YES \_\_\_\_\_ NO \_\_\_\_\_

**Signature Acknowledgement:** I certify that this information is correct. By signing this certification, I am authorizing PASSHE to provide coverage for my child identified above. I understand that it is my responsibility to notify Human Resources when my child becomes eligible for other employer-sponsored health coverage, and that failure to do so, or misrepresentation/falsification of facts on this form will make me personally liable for the cost of any claims incurred during the time that my child is ineligible for PASSHE health coverage. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Return the completed form to your university Human Resources office**