Certification of Over-Age Dependent Eligibility Form

Employee ID:		Phone Number:	
Employee/Retiree Name:		Email Address:	

In accordance with Florida Statute 627.6562, certain children must meet specific eligibility requirements to be covered under the City of Tampa Group Insurance health plan. In the event a claim is denied, it is the subscriber's sole responsibility to establish that the dependent(s) meet the requirements for continued eligibility. Additionally, the City of Tampa may request documentation to ensure that a child meets and continues to meet such requirements. This eligibility provision does not modify any other eligibility requirements. Please refer to your Plan Document for more information.

Children ages 26-30 are eligible to be covered as over-age dependents on the health plan if all the following apply:

- They are unmarried and do not have a dependent of his or her own,
- They are a resident of Florida or a full-time or part-time student, and
- They are not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

Please complete this section for your over-age dependents currently covered under the health insurance plan. All fields required.

Dependent Name	Relationship	Meets All Eligibility Requirements	School Attending if Out of State
		☐YES ☐NO	

If you stated Yes they meet all eligibility, please advise if you are choosing to cover your overage dependent for 2027. If yes, you will pay full premium after tax for that child in addition to any premium you pay for yourself or other eligible dependents that you choose to cover.

Dependent Name	I am choosing to cover my overage eligible dependent and understand I will pay full premium after tax for them
	☐YES ☐NO

I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage. Any person who knowingly and with 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 pursuant to s. 817.234, Florida Statutes. I hereby affirm and attest to my response on the eligibility requirements for the dependent(s) listed above.

_____ _____

Employee/Retiree Signature Date

Please email or mail to: benefits@boibenefits.com

Benefits Outsource
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Davie, FL 33328