AFFIDAVIT OF DEPENDENCY
Health Benefits Program

To enable the County of Monmouth to determine the eligibility of the dependent child (ren) listed on my Health Benefits application of coverage in the Monmouth County Program, I state the following with respect to the child (ren) listed below.

Employee Name :______________________________ **Social Security:**________________________

Department:__________________________________ **Work phone:**__________________________

RELATIONSHIP (check one)	RESIDENCE (check one)	FINANCIAL SUPPORT (check one)
☐ My child(ren)	☐ Live(s) with me	☐ Substantially dependent on me for support and maintenance
☐ My stepchild(ren)	☐ Do(es) not live with me	☐ Not substantially dependent on me for support and maintenance
☐ Other ____________	☐ Other ____________	

Name (s) of Child(ren) Last Name	First Name	Date of Birth Month-date-year	Social Security #

I certify that the statement and information submitted above is correct.

____ ______________________
Print Full Name Date

____
Address

____
Signature (must be the same name as printed above)

State of ______________________County of _________________________

Sworn and subscribed before me this _______________ of _________________

My Commission expires ____

Signature of Notary Public ____

Official Title ____