Jefferson Federation of Teachers
HEALTH AND WELFARE FUND
2540 SEVERN AVENUE, SUITE 302, METAIRIE, LOUISIANA 70002
MAILING ADDRESS: P.O. BOX 6137, METAIRIE, LA 70009-6137
PHONE 504-455-7261

ELIGIBILITY DATE

ENROLLMENT AND VERIFICATION FORM FOR DEPENDENT ELIGIBILITY

EMPLOYEE'S LAST NAME	EMPLOYEE'S FIRST NAME (IN FULL)	EMPLOYEE'S MIDDLE NAME (IN FULL)	

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	E-MAIL

SOCIAL SECURITY NUMBER	JPPSS EMPLOYEE NO.	GENDER	DATE OF BIRTH	MARRIED/SINGLE DIVORCED/WIDOWED (Circle one)

- **Review the *Definitions and Required Documentation* for each Dependent listed.**
- **Complete this Verification Form, verifying each listed Dependent's eligibility for benefits.**
- **Submit the required documentation, along with the signed Verification Form by mail or pony to the address listed above. Please write your name and JPPSS Employee No. on the top right hand corner of each document you submit.**

DEPENDENT'S FULL NAME	GENDER M or F	DATE OF BIRTH	SOCIAL SECURITY NO	RELATIONSHIP & DEPENDENT TYPE Check all that apply	
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19
				☐ Legally Married ☐ Biological Child ☐ Adopted Child ☐ Stepchild	☐ Court-Ordered Guardian ☐ Court-Ordered (QMSCO) ☐ Dependent aged 19-23 ☐ Disabled Child over age 19

Declaration: By signing this Verification Form, I attest that I have reviewed the Dependent Eligibility Definitions and confirm that the above listed Dependents qualify as Eligible Dependents under the Plan. I hereby certify that the information I am submitting is true and accurate to the best of my knowledge. I understand that knowingly providing false or misleading information on this Form may result in disciplinary action up to and including termination of coverage. I also understand that if I present false information resulting in the enrollment of ineligible Dependents, I am responsible for repaying any claims paid by the Plan, and any premium payments made by me will not be refunded. The Fund may request additional information or documents to verify Dependent Eligibility status, to evidence financial dependency upon Employee for support.

SIGNATURE: ______________________________ **DATE:** ____________________