CERTIFICATION FOR FOSTER CHILD

I have been informed of the following requirements for coverage of a foster child under the Federal Employees Health Benefits Program and/or the Option C Family coverage under the Federal Employees' Group Life Insurance:

- The child must be unmarried and under the age of 22. (If the child is over age 22, he/she can only be covered if he/she is incapable of self-support because of a disabling condition that began before age 22. I must provide documentation of this to my Human Resources Office).

- The child must be living with me.

- The parent-child relationship must be with me, not with the biological parent. This means that I am exercising parental authority, responsibility, and control; I am caring for, supporting, disciplining, and guiding the child; I am making the decisions about the child's education and health care.

- I must be the primary source of financial support for the child.

- I intend to raise the child into adulthood.

I understand that if the child moves out of my home to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that _____ (child) meets all of the requirements stated above. I will immediately notify both my servicing Human Resources office and my health benefits carrier if the child marries, moves out of my home, or ceases to be financially dependent on me.

_____ _____

Signature of Employee Date

_____ _____

Printed Name of Employee Social Security Number

5/2004