**EMPLOYEES RETIREMENT SYSTEM OF TEXAS**
P. O. Box 13207, Austin, Texas 78711-3207
(512) 867-7711 or (877) 275-4377 (toll-free)

# DEPENDENT CHILD CERTIFICATION

Texas Employees Group Benefits Program (GBP)

*Information provided to the Employees Retirement System of Texas (ERS) is maintained for administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify your benefits coordinator or ERS.*

Complete a separate form for each dependent child to be covered who is not your natural or adopted child.

## SECTION A: *PERSONAL DATA*

| Employee/Retiree Name (Last, First, M.I.) | Social Security No. | EmplID | DeptID |
|---|---|---|---|
| | | | |

| Legal Name of Child (Last, First, M.I.) | Child's Social Security No. (Required for 12 months or older) | Child's Birth Date (mm-dd-yyyy) | Date Child Moved Into Employee's Household (mm-dd-yyyy) |
|---|---|---|---|
| | | | |

## SECTION B: *DEPENDENT CHILD CATEGORY*

Check the one statement below which describes your relationship to the dependent child named above.

☐ 1. I certify that the child named above is my stepchild and his/her primary residence is my household.

☐ 2. I certify that I am the legal guardian of the child named above and his/her primary residence is my household.

☐ 3. I certify that the child named above is my foster child, his/her primary residence is my household and he/she is not covered by another governmental health program.

☐ 4. I certify that I have assumed all parental responsibilities for the child named above; his or her primary residence is my household; and the natural parent is under age 21. The natural parent's date of birth is _____.

☐ 5. I certify that I have assumed all parental responsibilities for the child named above and his or her primary residence is my household. The natural parent is age 21 or older and does not reside in my household. The natural parent's date of birth is _____.

☐ 6. I certify that the child named above is considered my dependent for federal income purposes and is a child of my child.

## SECTION C: *CERTIFICATION*

*I certify that all information provided above is valid and true to the best of my knowledge. I understand that a fraudulent statement may be cause for expulsion from this Program. I understand that I may be requested to provide documentation to verify the above-named dependent child's eligibility for coverage. If there is a change in the eligibility status of my dependent, I understand that it is my responsibility to drop the dependent from coverage within 30 days of losing eligibility.*

_____ _____

**Signature of Employee/Retiree** **Date Signed (mm-dd-yyyy)**