CERTIFICATION FOR FOSTER CHILDREN

I have been informed of the following requirements for coverage of a foster child under the Federal Employees Health Benefits Program:

1. The child must be under age 26. (If the child is age 26 or older, he/she can only be covered if he/she is incapable of self-support because of a disabling condition that began before age 26. I must provide documentation of this to my employing office.);

2. The child must currently live with me;

3. I must currently be the primary source of financial support for the child;

4. The parent-child relationship must be with me, not with the biological parent. This means that I exercise parental authority, responsibility, and control. I care for, support, discipline, and guide the child. I make the decisions about the child's education and health care; and

5. I must expect to raise the child into adulthood.

I understand that if this 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 a disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that: _____ (name of child) lives with me; I am the primary source of financial support for this child; I have a regular parent-child relationship with this child, as described above; and I intend to raise this child into adulthood.

I have provided my employing agency proof of my regular and substantial support for _____ (name of child).

I will immediately notify both my employing office and the health benefits carrier if this child moves out of my home or ceases to be financially dependent on me.

_____ _____

Print name of enrollee Social Security Number

_____ _____

Enrollee signature Date