



**INSTRUCTIONS:** This form must be completed when an enrollee applies for coverage on behalf of a dependent child who is other than the enrollee's own child, adopted or dependent stepchild. For such a dependent to be eligible, the child must, among other things, (1) reside permanently in the enrollee's home and (2) receive more than 50 percent of support from the enrollee, including medical expenses. If you have a dependent who meets these criteria, please complete this form and submit proof of support.

Please read carefully, respond accurately and initial your response to each of the following questions. If you have questions, contact your agency Health Benefits Administrator.

**Part A- ENROLLEE'S STATEMENT**

Enrollee's Name		Health Insurance Identification Number		
Enrollee's Address	No. and Street	City	State	Zip Code
Enrollee's Agency (if on the payroll)		Telephone Work (    )	Home (    )	
Dependent's Name		Dependent's Birth Date		

- 1 . What relationship is the dependent to you? \_\_\_\_\_
- 2 . Who has legal custody of this dependent? \_\_\_\_\_
3. Check one: Acting in place of the parent ("*in loco parentis*") for this dependent, I  have  have not assumed responsibility for medical expenses for the above named dependent until the child is age 19 or is otherwise no longer eligible for enrollment in the New York State Health Insurance Program.
4. What percent of the dependent's support do you provide? \_\_\_\_\_  
  
Please supply documentation of this support: for example, papers indicating legal guardianship or a copy of your Federal tax return listing the individual as a dependent. If you do not claim the dependent on a tax return, we will accept a letter from a CPA or an attorney that the dependent could be claimed on your tax return under current IRS regulations if you chose to do so.
5. Is your home the permanent legal residence of this dependent?     Yes     No  
Explain \_\_\_\_\_
6. How long do you anticipate such legal residence will continue? \_\_\_\_\_  
Be specific; duration of residence if categorized as "indefinite" or "unknown" is not qualifying.

**The State may request such proof of support and/or residency that may be satisfactory to it.**



STATE OF NEW YORK  
DEPARTMENT OF CIVIL SERVICE  
THE STATE CAMPUS  
ALBANY, NEW YORK 12239

**EMPLOYEE BENEFITS DIVISION**  
**STATEMENT OF DEPENDENCE**  
**FOR PARTICIPATION IN THE HEALTH INSURANCE PROGRAM**

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**PERSONAL PRIVACY PROTECTION LAW NOTIFICATION**

This information is being requested pursuant to Section 164 of the New York State Civil Service Law and NYCRR Rule 73.4 for the principal purpose of determining eligibility of individuals to participate in these programs and to maintain up-to-date records for covered employees. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide this information may result in the disapproval of an individual to participate in these programs or a delay in the payment of benefits. This information will be maintained by the Director of Personnel or the Health Benefit Administrator of the agency where you are employed. For further information relating **only** to the Personal Privacy Protection Law call (518) 457-9375.

This information must be true and accurate, pursuant to the following:

**Section 1035 of Title 18 of the United States Code:**

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully - (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statement or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

**Section 86.4 of title 11 of the New York Compilation of Rules and Regulations:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Section 176.05 of the Penal Law:**

A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self insurer, or purported insurer, or purported self insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy, or certificate or evidence of self insurance for commercial insurance or commercial self insurance, or a claim for payment or other benefit pursuant to an insurance policy or self insurance program for commercial or personal insurance which he knows to: (i) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto.

Date	Enrollee's Signature
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Sworn to before me this

Day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

**Part B—FOR OFFICE USE ONLY**

<input type="checkbox"/> Approved	Date Transaction submitted to add Dependent (if necessary) _____
<input type="checkbox"/> Disapproved	
Date	Signature of Health Benefit Administrator

**THIS FORM MUST BE RETAINED BY THE EMPLOYING AGENCY WITH THE ENROLLEE'S ENROLLMENT RECORDS.**