East End Health Plan
Young Adult Insurance Coverage Affidavit

In order to receive Young Adult Insurance Coverage through the East End Health Plan, I hereby certify that: (Please check all that apply.)

- ☐ **1. I am unmarried;**
- ☐ **2. I am 29 years of age or under;**
- ☐ **3. I am not insured or eligible for insurance through my own employer;**
- ☐ **4. I live, work or reside in New York State or the health insurance company's service area;**
- ☐ **5. I am not covered by Medicare;**
- ☐ **6. My parent, stepparent, or adoptive parent, is currently employed or is a retiree of the school district from which I am requesting coverage and that parent has coverage through the East End Health Plan.**

(You do not have to live with your parent, be financially dependent on a parent or be a student to qualify for this coverage.)

I understand that the amount of this insurance is $_____ per month. I will be billed by J.J. Stanis and Company on a monthly basis and payment is due by the last day of the month prior to the month of coverage. If I do not pay within the grace period, insurance will AUTOMATICALLY terminate without additional notice from the East End Health Plan and I will not be reinstated.

I am aware that if I am eligible for COBRA and am choosing the Young Adult Coverage instead, if my parent becomes no longer employed by the school district or loses EEHP coverage, the Young Adult coverage will be terminated and I will not be eligible for COBRA.

It is my responsibility to notify the East End Health Plan in writing when insurance should be terminated.

Name: _____

Social Security Number: _____

Date of Birth: _____

Signature: _____

A COPY SHOULD BE RETAINED WITH THE APPLICATION FOR INSURANCE.