

FEHB 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: _____ lives with me.
(name, date of birth and SSN of child)

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

Enrollee's Social Security Number

Enrollee signature

Date