



Broward County Human Resources Division
 Employee Benefit Services Section
 115 S Andrews Avenue, Ste. 514, Fort Lauderdale FL 33301
 Office: 954-357-6700 | Secured Facsimile: 954-728-2777
 Email: Benefits@broward.org | Website: Broward.org/Benefits

Broward County Benefit Plans allow medical coverage for dependents from the age of 26 through the end of the year in which they turn 30; if all criteria below are met. If dependent was not previously covered under your benefit plans, dependent must have been continuously covered by other creditable coverage without a gap in insurance exceeding sixty-three (63) days after the end of the year in which he/she reached age 26. Proof of creditable coverage must be submitted at time of enrollment.

The Over Age Dependent benefit is subject to a **\$20 biweekly surcharge if enrolled in medical coverage.**

Employee Last Name: _____ First Name: _____

Employee ID#: _____ Dependent's Name: _____

Dependent's Date of Birth: _____ Dependent's Age on January 1, 2023: _____

1. Is unmarried; and
2. Has no dependents of his/her own (i.e., children, domestic partner, etc.); and
3. He/she is dependent on Broward County employee ("you") for financial support; and
4. Is not provided coverage or covered under any other group or individual health benefit plan; and
5. Is not entitled to benefits under Title XVIII of the Social Security Act; and
6. Is a resident of Florida or is a full or part-time student; and
7. Has creditable, coverage without a gap, not exceeding 63 days prior to January 1, 2023.

Does the dependent meet Criteria 1 through 7 as listed above? Yes No

Will the dependent be a financial or student dependent in 2023? Financial Student

Financial Dependent Documentation: Please submit this Affidavit and a copy of the dependent's Florida driver's license or State-issued identification showing a valid Florida address.

Student Documentation: Please submit this Affidavit and 2022 school schedule. (Proof of student status must include the following, preprinted by the educational institution: 1) Name of educational institution; 2) Name of dependent; 3) Date of semester showing enrollment for 2022.

EMPLOYEE ACKNOWLEDGEMENT

I have read the rules pertaining to coverage for Over Age Dependents. I understand that the portion of the premium attributable to my Over Age Dependent cannot be deducted pre-tax and that I will pay imputed income tax on the portion of the subsidy attributable to the Over Age Dependent's coverage. Over Age Dependents are not eligible to receive reimbursement from a Health Savings Account (HSA) or Health Reimbursement Account (HRA) unless claimed as a dependent on your income taxes. Employees will not receive the portion of the HRA attributable to coverage of an Over-Age Dependent. Eligible medical expenses incurred may be reimbursable from the Health Savings Account (HSA), subject to IRS guidelines.

I acknowledge that I have provided true and official documentation; and that the dependent listed above meets the eligibility criteria, as specified by Broward County. If a post audit of the enrolled dependent shows that he/she does not meet the eligibility requirements of the plan, I understand that I will be held legally and financially responsible for the repayment of all benefit claims incurred by my ineligible dependent. Florida Statute 817.234 clearly states that any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Any person committing such fraud will be subject to appropriate action by Broward County and/or the insurance carrier.

Employee Signature: _____ Date: _____

Complete this form and submit with supporting documents to:
benefits@broward.org or Fax 954-728-2777

EBS USE ONLY	EFFECTIVE DATE	APPROVED	REVIEWED
--------------	----------------	----------	----------

**EMPLOYEES WITH DOMESTIC PARTNER COVERAGE
AND/OR OVER AGE DEPENDENT (CHILD AGE 26-30 on 1/1/2022) COVERAGE**

Per IRS rules, deduction is broken into pre- and after-tax; a portion of the County's subsidy is subject to Imputed Income tax.

FULLTIME	UHC HDHP Base					UHC HDHP OON (In/Out-of-Network)				
	Deduction			Imputed Income	Annual HSA/HRA	Deduction			Imputed Income	Annual HSA/HRA
	Full	Pre-Tax	After-Tax			Full	Pre-Tax	After-Tax		
Emp+CH over 26 (Child+\$20)	39.91	10.39	29.52	218.23	2,400	59.98	21.52	38.46	241.26	2,400
Emp+Family w/ child over 26 (Family+\$20)	96.94	26.59	70.35	219.20	2,400	109.81	48.42	61.39	265.99	2,400
Emp+DP	26.59	10.39	16.20	296.13	2,400	48.42	21.52	26.90	329.27	2,400
Emp+CH of DP	19.91	10.39	9.52	218.23	2,400	39.97	21.52	18.45	241.26	2,400
Emp+CH of DP over 26 (CH+\$20)	39.91	10.39	29.52	218.23	2,400	59.98	21.52	38.46	241.26	2,400
Emp+DP+CH w/ no child of DP	76.93	19.91	57.02	297.10	2,400	89.81	39.97	49.84	354.01	2,400
Emp+DP+CH of DP	76.93	10.39	66.54	515.33	2,400	89.81	21.52	68.29	595.27	2,400
Emp+DP+CH over 26 w/ no child of DP (Fam+\$20)	96.94	10.39	86.55	515.33	2,400	109.81	21.52	88.29	595.27	2,400
Emp+DP+CH of DP over 26 (Fam+\$20)	96.94	10.39	86.55	515.33	2,400	109.81	21.52	88.29	595.27	2,400

FULLTIME	UHC CDH				
	Deduction			Imputed Income	Annual HRA
	Full	Pre-Tax	After-Tax		
Emp+CH over 26 (Child+\$20)	165.11	78.64	86.47	303.52	0
Emp+Family w/ child over 26 (Family+\$20)	293.13	171.62	121.51	336.33	0
Emp+DP	171.62	78.64	92.98	414.48	0
Emp+CH of DP	145.11	78.64	66.47	303.52	0
Emp+CH of DP over 26 (CH+\$20)	165.11	78.64	86.47	303.52	0
Emp+DP+CH w/ no child of DP	273.12	145.11	128.01	447.29	0
Emp+DP+CH of DP	273.12	78.64	194.48	750.81	0
Emp+DP+CH over 26 w/ no child of DP (Fam+\$20)	293.12	78.64	214.49	750.80	0
Emp+DP+CH of DP over 26 (Fam+\$20)	293.12	78.64	214.49	750.80	0