



# DECLARATION OF DEPENDENT ELIGIBILITY DISABLED DEPENDENT

I, \_\_\_\_\_, submit this *Declaration of Dependent Eligibility* to establish  
NAME OF EMPLOYEE

\_\_\_\_\_ as my dependent according to the Disabled Dependent rules of my  
NAME OF DEPENDENT

District for the purpose of qualifying for any benefits that the District may extend to employees and their dependents.

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I declare and acknowledge the following: \_\_\_\_\_ is determined to be disabled by a  
NAME OF DEPENDENT  
competent medical authority.

I have an obligation to file an eligibility change form with my district within 30 days of a change in my disabled dependent's condition.

I understand that I am responsible for the reimbursement of any expenses incurred as a result of any false or misleading statements contained in this *Declaration of Dependent Eligibility*, including claims paid under any benefit plans in which I enroll my dependent. Additionally, I understand that enrolling a dependent over the age of 19 who does not meet the Disabled Dependent Standards of my District may have severe tax consequences for me or my dependent.

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I declare, under penalty of perjury, that the foregoing is true and correct and that this *Declaration* was executed at \_\_\_\_\_, California. Furthermore, I understand that neither the District nor the Southern California Schools Voluntary Employees Benefits Association will provide legal advice and I should consult my attorney regarding the possible legal implications of filing the *Declaration of Dependent Eligibility*.

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**Employee Signature**

**Date**

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**Print Name of Employee**

**Name of Dependent**

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**Employee Social Security Number**  
Number

**Dependent Social Security**

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**Employee Address (Street, City, State, Zip Code)**

**School District**

**Mail Completed Form to:**

Southern California Schools VEBA  
C/o McGregor Van De Moere Inc.  
7676 Hazard Center Drive, Suite 300  
San Diego, CA 92108