Department of the Navy
Civilian Benefits Center

Foster Child Certification

Complete this form and fax it to 207-255-4329 or mail it to: Human Resources Benefits Contact Center
P.O. Box 629
East Machias, ME 04630

Employee Name:	**Last 4 Digits of Employee's SSN:**	
Child's Name:	**Last 4 Digits of Child's SSN:**	**Child's DOB:**

I desire to include the foster child listed above under the benefits programs for which I have elected to participate. I have been informed of the following requirements for coverage of a foster child under these programs:

- For health insurance, the child must be younger than age 26. For life insurance and the dental and vision programs the child must be younger than age 22. (If the child is older than age 22, he or she can only be covered if he or she is incapable of self-support because of a disabling condition that began before age 26. I will provide documentation of this to the Civilian Benefits Center).
- The child must currently live with me.
- I must currently be the primary source of financial support for the child.
- The parent-child relationship must be with me, not with the biological parent. This means that I am exercising parental authority, responsibility, and control; I am caring for, supporting, disciplining, and guiding the child; I am making decisions about the child's education and health care.
- I must expect to raise the child to adulthood.

I understand that if the child moves out of my home to live with a biological parent, he or 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.

I certify that the foster child listed above lives with me; 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 to adulthood.

I will immediately call the Benefits Line at 888-320-2917 and the health insurance/dental and/or vision carrier if the child moves out of my home or ceases to be financially dependent on me.

I have provided the Department of the Navy Civilian Benefits Center with proof of my regular and substantial support for the child listed above.

Employee Signature	Telephone Number	Date

PRIVACY ACT NOTICE

We are authorized to request this information under 5 U.S.C. Chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. You are not required by law to provide this information, but if you do not provide it, it may not be possible to process the actions you request.