Clear Form

GENERAL AFFIDAVIT

STATE OF _____)
) SS.
COUNTY OF _____)

PERSONALLY came and appeared before me, the undersigned Notary, the within named _____, who is a resident of _____ County, State of _____, and makes this his/her statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge:

I (Affiant) _____ hereby attest that my child, _____, is not eligible for Medicare Part B. I understand that my child is eligible for regular or disability Medicare Part B if he/she meets the following:

1. Regular Medicare Part B eligibility requirements:
   - 65 years of age or older and a US resident,
   - US citizen or an alien who has been lawfully admitted for permanent residence and has been residing in the US for five continuous years prior to the month of filing an application with Medicare.
2. Medicare Part B eligibility due to disability requirements
   - Individuals entitled to monthly Social Security or Railroad Retirement Board benefits on the basis of disability are automatically entitled to Medicare Part A after receiving disability benefits for 24 months,
   - Individuals who are eligible for premium free Medicare Part A are also eligible for Medicare Part B.

I understand that enrollment of a dependent of a retiree or surviving spouse of a retiree, in Medicare Part B is required by the Hawaii Employer-Union Health Benefits Trust Fund Administrative Rules. Should my dependent child become eligible for Medicare Part B, I will enroll my dependent child in Medicare Part B and provide proof of enrollment to the Hawaii Employer-Union Health Benefits Trust Fund.

DATED this the_____ day of _____, 20 .

_____
Signature of Affiant

SWORN to and subscribed before me, this the _____ day of_____, 20 .

_____
NOTARY PUBLIC

My Commission Expires:

_____

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