AFFIDAVIT OF RESPONSIBILITY (Step-Children)

Name of Employee Plan Participant: _____

Coverage is being requested for my dependent(s) listed below:

Name	Date of Birth	Relationship to both Employee & Spouse

I, the undersigned, affirm and attest to the following facts:

1. that the above listed dependent(s) maintain a parent/child relationship with the employee and
2. that the above listed dependent(s) are under the age of 26.

_____ _____

Name of Employee Plan Participant (Please Print) | Signature of Employee Plan Participant

_____

Date

County Technical Services, Inc.

Administration & Loss Prevention
Phone: 303•861•0507
Fax: 303•861•2832

800 Grant Street • Suite 400
Denver, Colorado • 80203
email: ctsi@ctsi.org

Claims (CAPP & CWCP)
Phone: 303•861•0507 1-800•544•7868
Fax: 303•861•1022