



**CERTIFICATION OF DEPENDENCY  
CLARKSVILLE MONT.CO.SCHOOLS**

**Subscriber Name** \_\_\_\_\_ **Social Security#** \_\_\_\_\_

**For purposes of establishing eligibility for dependent health care benefits, the undersigned certifies as follows:**

1. Dependent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- 2. Dependent Status:
  - Natural Child
  - Step-Child
  - Foster Child (Please attach placement contract signed by the representing agency)
  - Adopted Child (Please attach final decree or placement contract signed by the representing agency/Judge.
  - Other-Explain: \_\_\_\_\_

- 3. Dependent is:
  - A.  Married     Single     Divorced     Widowed
  - B. A full-time student?  Yes  No  
If no is child being claimed on your annual income tax?  Yes  No
  - C. Residing full-time in your home?  Yes  No
  - D. Receiving income or support from any other source?  Yes  No  
If yes, please indicate source and monthly amount: \_\_\_\_\_

4. What additional support do you provide? I provide \_\_\_\_% of this dependent's support.

5. Has the dependent been incapable of self-support due to a physical or mental handicap?  Yes  No

6. Is there a divorce decree ordering you to provide insurance or pay medical expenses for this dependent?  Yes  No

If yes, please attach copy, including page bearing judge's signature denoting finalization.

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date