HUMAN RESOURCES
& DEVELOPMENT
TULARE COUNTY

Dependent Verification Form

Employee's Name: ______________________________

Employee ID: ______________________________

Social Security Number: ______________________________

Please submit this form with the appropriate documentation for each of your covered dependents. Attach the documents to this form using a staple or paper clip.

Dependent Name		**Verification Enclosed**		
		Current Tax Return	Marriage License	Birth Certificates
Spouse		☐	☐	
Dependent		☐		☐
Dependent		☐		☐
Dependent		☐		☐
Dependent		☐		☐

I have enclosed the appropriate documentation for each of my covered dependents as indicated above. I understand that any dependent not verified will be considered ineligible for coverage under Tulare County's Health Plan and removed from my coverage. I further understand that ineligible dependents removed as a result of this audit cannot re-enroll as my dependent in any Tulare County Health Plan.

______________________________ ______________________

Employee's Signature Date

Mail: Human Resources & Development
Benefits Department
2500 W Burrel Ave
Visalia, CA 93291

Fax: (559) 615-3022

Scan & Email: OEHealth@tularecounty.ca.gov