



**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		<input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>

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 Burrell Ave  
Visalia, CA 93291

**Fax:** (559) 730-2597

**Scan & Email:** [OEHealth@tularecounty.ca.gov](mailto:OEHealth@tularecounty.ca.gov)