



**Declaration of Legal Ward  
as Eligible Dependent**

**Health Insurance Subscriber:**

Last Name	First Name	Social Security Number
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**Enrolled Dependent:**

Last Name	First Name	Social Security Number
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**You must complete one form for each Legal Ward enrolled.**

**Declaration:**

I, a LANS Health Plan Subscriber, have the dependent listed above enrolled on my LANS Health Insurance coverage and certify by signing this declaration that he or she meets all the requirements below as defined in the LANL Health & Welfare Benefit Plan for Active Employees.

1. This enrolled dependent is unmarried and under the age of 18.
  2. This enrolled dependent is living with me.
  3. This enrolled dependent will receive more than half of his or her support from me during the current tax year and will be claimed as my tax dependent.
- I agree that I will notify the LANS HR-Benefits Office within 31 days if there is any change in the circumstances attested to in this declaration, including any change that disqualifies this dependent as being eligible for LANS Health Plan benefits.
  - I understand that falsely certifying such qualification could result in serious consequences, including termination from the Plan.
  - I will submit this completed declaration to LANS HR-Benefits Service Center by required deadlines to have my payroll deductions for health benefits changed during the next applicable pay period.

**I declare under penalty of perjury the foregoing is true and correct.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

How to Return Your Completed and Signed Declaration Form  
(Please keep a copy for your records):

LANS Benefits Service Center  
P.O. Box 1663, MS P280  
Los Alamos, NM 87545-0001  
Fax to: 505-665-2156  
Email to: [Benefits@lanl.gov](mailto:Benefits@lanl.gov)