

**AFFIDAVIT**

State of \_\_\_\_\_ )  
City \_\_\_\_\_ ) ss.  
County \_\_\_\_\_ )

File#: \_\_\_\_\_

I, \_\_\_\_\_, ("Affiant"), a member of the Denver Employees' Retirement Plan, being of lawful age, state under oath and certify the following:

1. I am currently enrolled in health insurance with:  
Name of Insurance Company: \_\_\_\_\_.  
Address: \_\_\_\_\_.  
Group Number: \_\_\_\_\_
2.  This insurance only covers Affiant.  
 This insurance covers Affiant and my spouse.  
 This insurance covers Affiant and my spouse and/or qualified dependent(s).
3. The monthly premium for this insurance (including the amount for spouse and/or qualified dependent(s) is \$ \_\_\_\_\_.
4. The Member insurance number for Affiant is: \_\_\_\_\_.  
The Member insurance number for Affiant's spouse (if applicable) is: \_\_\_\_\_.  
The Member insurance number for Affiant's dependent(s) (if applicable) is: \_\_\_\_\_.
5. The renewal date for Affiant is: \_\_\_\_\_.  
The renewal date for Affiant's spouse (if different than Affiant) is: \_\_\_\_\_.  
The renewal date for Affiant's dependent(s) (if different than Affiant) is: \_\_\_\_\_.
6. I understand that the Denver Employees' Retirement Plan, pursuant to Section 18-413 of the Revised Municipal Code of the City and County of Denver, will reimburse a portion of my payments of the premium, for the current insurance contract term, by paying to the Affiant such amount in arrears, and in doing so conclusively rely upon the statements and representations sworn to in this Affidavit with regard to the health insurance, the premiums and the renewal dates.
7. I have enclosed proof of insurance which verifies enrollment in health insurance, the premium payment amount and the renewal dates for Affiant and, if applicable, my spouse and/or dependent(s).
8. The Affiant, if called as a witness, is competent to testify and would testify to the facts stated in this Affidavit.
9. I agree to notify the Plan immediately, in writing, if my health insurance is cancelled for any reason, and I understand that should I become disqualified from receiving the reimbursement, such as by my death, my spouse, if any, and/or dependents shall not be entitled to the reimbursement from that date forward.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Print Name

I, the undersigned authorized official, do hereby state and affirm that the above-named Affiant signed and acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, the Affidavit hereinabove.

\_\_\_\_\_  
Notary (or other authorized official)

My Commission Expires \_\_\_\_\_