U.S. Department of State

CERTIFICATION FOR FOSTER CHILD STATUS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFIT (FEHB) PROGRAM

INSTRUCTIONS:
Submit the DS-5111-H, **Certification for Foster Child Status under the Federal Employees Health Benefits (FEHB) Program**, to the HR Service Center at HRSC@state.gov or via fax to 1-843-202-3807.

CERTIFICATION OF FOSTER CHILD STATUS

This is to certify that my foster child meets the following requirements for coverage under my enrollment in the Federal Employees Health Benefits (FEHB) Program:

- The child is unmarried and is under age 26 or over age 26 and incapable of self-support because of a disability that existed before age 26
- The child lives with me in a regular parent-child relationship
- I contribute regular and substantial support for the child
- I intend to raise the child into adulthood

NOTE: If the child is a newborn, provide social security number to health benefits carrier as soon as it becomes available. Do NOT send the Social Security Number (SSN) to the Human Resources Service Center (HRSC).

Section 1: Foster child's information: in order to make the alert system effective.

Child's Full Name *(Last, First, Middle)*	Child's Date of Birth *(mm-dd-yyyy)*

Section 2: Employee Verification Statement

I have enclosed a Government-issued birth certificate or other document verifying my foster child's date of birth. I have also enclosed proof of my regular and substantial support for my foster child such as:

- Evidence of eligibility as my dependent child for benefits under other State or Federal programs
- Proof of inclusion of the child as a dependent on my income tax returns
- Canceled checks, money orders, or receipts for periodic payments from me for or on behalf of the child
- Evidence of goods or services which show regular and substantial contributions of considerable value
- Any other evidence which the Office of Personnel Management, in guidance, deems to be sufficient proof of support

I understand that I am required to immediately notify HRSC and my health benefits carrier if the child marries, moves out of my home, or ceases to be financially dependent on me. I understand that if this child moves out to live with a biological parent, the child loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to a disability.

This form will be maintained in your Official Personnel Folder (OPF) with the SF 2809 - Health Benefits Form, if applicable.

WARNING: Any intentionally false statement or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001).

Employee's Full Name *(Last, First, Middle)*	Employee's SSN
Email Address	Phone Number
Signature	Date *(mm-dd-yyyy)*

To Be Completed By Agency or Retirement System

REMARKS (Include description of types of documents reviewed and findings)

Date Received *(mm-dd-yyyy)*	Effective Date of Action *(mm-dd-yyyy)*	Personnel Telephone Number
Name and Address of Agency or Retirement System		Authorizing Official (*Please Print*)
		Signature of Authorized Agency Official

Privacy Act Statement

AUTHORITY: The information is sought pursuant to the Federal Employees Health Benefits (FEHB) Program - Affordable Care Act, Extension of Dependent Coverage, 42 U.S.C.§ 300gg-14.

PURPOSE: To comply with the Federal Employees Health Benefits (FEHB) Program - Affordable Care Act (ACA), Public Law 111-148, which allows eligible foster child(ren) to be covered under their parent's Self and Family enrollment until age 26. The information furnished may also be used to certify that certain requirements are met.

ROUTINE USES: The personal information including your SSN provided on this form is needed to document your enrollment in the Federal Employee Health Benefits Program (FEHB) under Chapter 8, Title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may identify your enrollment in the plan, verify you and your family's eligibility for payment of a claim for health benefits services and may be used as an individual identifier in the FEHB Program.

EFFECTS OF NON-DISCLOSURE: Providing personal information, including your SSN and signing the new certification agreement is voluntary, but failure to provide certain information and meet requirements may result in denial of health insurance benefits and supplies for eligible foster child(ren).