County of Onondaga
Personnel Department
John H. Mulroy Civic Center, 11th Floor
421 Montgomery Street, Syracuse, NY 13202
Phone: 315.435.3537 Fax: 315.435.8272
employeebenefits@onondaga.gov

J. Ryan McMahon, II
County Executive

Carlton Hummel
Commissioner

Open Enrollment Student Dependent Certification Form

In accordance with the Onondaga County Dental Benefit Plan, once a dependent reaches the age of 19, the dependent no longer meets the eligibility requirements for coverage unless they are currently attending one of the following: *high school, a licensed trade school, or an accredited institution of higher learning as a full-time student.*

If your dependent meets one of the above listed criteria, please complete the ***Student Certification Form*** and submit proof that the dependent is a full-time student.

Acceptable documents include:

- An official enrollment verification letter from the college or university stating the student is enrolled full time for the ***Spring 2027*** semester.
- A ***Spring 2027*** class schedule that indicates full-time credit hours – *dependent's name and semester must be listed.*
- A registrar's certification of enrollment.

Completed documentation can be emailed to employeebenefits@onondaga.gov

Please contact the Employee Benefits Department at (315) 435-3498 with any questions.

Employee Name: _____ Employee Birth Date: _____

Dependent Name: _____ Dependent Birth Date: _____

2. What enrollment period/semester is this certification for? **Spring 2027**

This section is for High School Students Only

1. Is the dependent currently attending High School full-time? Yes No

a. What is the anticipated graduation date? ____/____/____

b. After graduating from High School will the dependent be attending College? Yes No

This section is for College Students Only

1. Is the Dependent currently attending College as a full-time Student? Yes No
If yes, what is the name of the College/University the dependent is attending? _____

I understand that dependent eligibility is subject to the terms and conditions of the Onondaga County dental insurance plan and my employer's benefits policy. I certify that the information provided is true and accurate.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Certified through: _____