AFFIDAVIT OF DEPENDENT ELIGIBILITY CONFIRMATION for The Eye Institute (TEI), Pennsylvania Ear Institute (PEI) and Speech-Language Institute (SLI) Benefit Program

Instructions:

- **Patient and Employee/Retiree:** Please fill out information and confirm your understanding of the eligibility requirements.
- **Submit this form** to the Clinic and at your time of appointment. *Without the Affidavit, family member(s) will be charged the full amount for services rendered. This affidavit will be required for each visit and will be valid for up to six months from the date of signature, or the date of employee's separation from Drexel, whichever is first.*

Purpose of the Affidavit:
I have provided the information in this Affidavit for the purpose of determining eligibility for the benefits offered under the program by The Eye Institute, the Pennsylvania Ear Institute, and the Speech-Language Institute:

1. **Accuracy of Information**:
   I certify that all representations and information provided as part of this Affidavit, are true, accurate, and complete.
2. **Provision of Additional Documentation**:
   I agree to provide any further documentation that may be required by Human Resources. I also agree to indemnify Drexel University for any expenses or liabilities it incurs as a result of any misrepresentations or inaccuracies, whether knowingly or unknowingly, in this Affidavit or in any information presented to a Human Resources representative.
3. **False or Misleading Statements**:
   I understand that any false or misleading statements made in this Affidavit may result in the denial of benefits and I may be subject to disciplinary action by Drexel University, including but not limited to the revocation of benefits.
4. **Payment/Responsibility**
   The University requires the application of any available insurance benefits which the employee or family members may have. Insurance information will be collected, and insurance companies will be billed for services as applicable.

Patient (Family Member)
First and Last Name _____ DOB: _____
Relation to Employee: _____ Cell Phone: _____
Home Address: _____

Employee
First and Last Name: _____
Employee ID #_____Phone #_____

I, _____[Full Name], an employee of Drexel University, confirm that the individual above qualifies as my eligible dependent for the Salus Clinic Benefits program, including Vision, Audiology and Speech, Language and Pathology (SLP), according to the Drexel University Salus Clinic Benefit Program requirements.

Employee Signature: _____
Printed Name: _____ [Employee Full Name]
Date: _____ [Date of Signing]