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
www.ongov.net

J. Ryan McMahon, II
County Executive

Carlton Hummel
Commissioner

STUDENT DEPENDENT CERTIFICATION

Employee Name: ______________________________ UMR Identification Number: ____________________

Name of Employer: Onondaga County or OCC Employment Status: Active or Retired

Dependent Name: ______________________________ Dependent Birth Date: ____/____/____

1. What enrollment period/semester is this certification for? Beginning ____/____/____ - Ending ____/____/____

2. Is the dependent covered under any other Dental Insurance Contract? Yes No.
If yes please provide the name of the insurance company, Identification No and phone number:
Name: ____________________________ Id No: _______________________ Phone No: ____________________

3. Is the dependent married? Yes No If Yes, Marriage Date: __________

This section is for High School Students Only

4. 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
c. If the dependent is no longer attending High School, please provide the date in which he/she stopped attending, or became a part-time student: __________

This section is for College Students Only

5. Is the Dependent currently attending College as a full-time Student? Yes No
a. If yes, what is the name of the College/University the dependent is attending? ____________________________
b. What is the anticipated graduation date? ____/____/____
c. If no, please provide the date in which he/she stopped attending school or became a part-time student: _________
d. After graduation will the dependent be attending Graduate School? Yes | No

I attest that the information shown above is true and complete. I agree to advise the County of Onondaga promptly of any changes in my child's dependent student status. I understand that any misrepresentation in the information I have provided above will permit the Onondaga County Dental Plan to terminate the dependent's membership and seek any other legal remedies available to the County of Onondaga.

Employee Signature: ________________________________ **Date:** __________________________

Employer Signature: ________________________________ **Date:** __________________________

Certified through: ________________________________