



L3HARRIS™

AFFIDAVIT OF EXTENDED FAMILY ELIGIBILITY

EMPLOYEE INFORMATION

Name: _____ L3Harris ID# _____

Address: _____ City _____ State/Zip _____

PATIENT INFORMATION (Complete one form for each patient)

Name: _____ Sex _____ Date of Birth _____

Address: _____ City _____ State/Zip _____

I hereby certify the above-named patient is related to me as follows (check one):

Spouse/Domestic Partner (not covered on L3Harris medical coverage)

Dependent Child (not covered on L3Harris medical coverage)

Adult Child

Parent (including In-laws and Step-parents)

Grandparent

Grandchild

Aunt

Uncle

Niece

Nephew

Cousin

Sibling (including stepsister/brother)

I have provided the above information for use by the L3Harris Family Medical Center (L3HFMC) and/or by the L3Harris Technologies for the purpose of determining my family member's eligibility to receive medical care provided by L3HFMC. I hereby certify that the information provided is true and correct to the best of my knowledge. I understand that providing untrue/false information could result in disciplinary action, up to and including termination from employment at L3Harris.

Employee Signature _____ Date _____