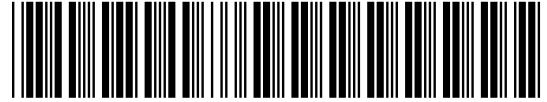




KENTUCKY PUBLIC PENSIONS AUTHORITY

1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov



Form 6456
Revised 11/2023

Print Form

Designation of Dependent Child

Member Information Please provide your Member ID or Social Security number in the Member ID box below.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:

Dependent Information

Dependent Name:	Dependent Social Security Number:	Date of Birth:	
Address:	City:	State:	Zip Code:

Complete the following if the dependent child is over the age of eighteen, unmarried, and a full-time student.

Dependent's School:	Phone Number:		
School Address:	City:	State:	Zip Code:

Certification

I, _____, do hereby state I am the parent or guardian of the dependent child as defined by KRS 16.505(17) and 78.510(49), or I am the dependent child over the age of 18, of the deceased member. I understand that benefits shall immediately cease when the person designated above no longer qualifies as a dependent child. I understand and agree that I will:

- Immediately provide written notification to the Kentucky Public Pensions Authority as soon as the person designated above marries, ceases to be a full-time student, or otherwise ceases to qualify as a dependent child as defined by KRS 16.505(17) and 78.510(49).
- Be responsible for repayment of any benefits paid to the person designated above if said person is not a dependent child as defined by KRS 16.505(17) and 78.510(49), or if I fail to notify the Kentucky Public Pensions Authority if said person no longer qualifies as a dependent child.

I hereby certify that the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I (personally) may be liable for restitution of the benefits for which the person designated above was not eligible to receive, civil payments, legal fees, and costs.

Signature: _____ Date: _____

Notary Certificate

State of: _____
County of: _____

The foregoing instrument was acknowledged before me this ____ of _____ 20____, by _____.

My Commission Expires: _____

Notary Public: _____

EXAMPLE