DEPENDENT ELIGIBILITY CERTIFICATION FORM

To: All Employees with Dependents Enrolled in the District's Medical/Prescription Drug Coverage

From:

Date:

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Please review the definition of Eligible Dependents below (which is also found in your Medical Mutual Benefit Book) to verify the eligibility of each of your dependents enrolled in the District's medical/prescription drug coverage. If any of your dependents (spouse or child) does not meet the eligibility definition below, please fill in (where indicated below) the name and other information for each ineligible dependent who needs to be removed from medical and prescription drug coverage with the District.

Definition of Eligible Dependents:

An Eligible Dependent is:
- your spouse;
- your or your spouse's children up to age 26 including the following:
  - natural children;
  - stepchildren;
  - children placed for adoption and legally adopted children;
  - children for whom either you or your spouse is the legal guardian or custodian; or
  - any children who, by court order, must be provided health care coverage by you or your spouse.

Eligibility may continue past the age limit for children who are unmarried and primarily dependent upon you for support due to a physical handicap or intellectual disability which renders them unable to work, in accordance with certain requirements as set forth in your Medical Mutual Benefit Book.

For Ineligible Dependent(s) to be Removed from Coverage, Fill In the Following Information:

Relationship	First Name	Last Name	Birthdate	Marriage Termination Date

Certification and Signature: I have read and understand the above definition of Eligible Dependents and hereby certify that all my enrolled dependents are eligible for medical/prescription drug coverage with the District based on the above definition, except the dependent(s) whom I have identified above as being ineligible, who need to be removed from coverage. I understand that I may be required to provide additional documentation. I further understand that I may be subject to disciplinary action, up to and including termination of employment, if I provide false information.

Employee Signature: ____ Date: ______________________

Complete and return this Form to the Treasurer's office no later than ________________________.

(7-2016)