GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

MEMBER ELIGIBILITY VERIFICATION FORM

EMPLOYEE INFORMATION:

Employee Last Name: ____________________ Employee First Name: _________________ Middle Initial: _______

Employee Social Security #:____-___-_____ Employee ID #: _____________Employee Date of Birth: ___________

Employee Mailing Address: ____
Street City State Zip

Employee Home Address: ____
(If different) Street City State Zip

Employee day time phone #: ________________________

Marital Status (circle one): Single / Married / Domestic Partnership / Separated / Divorced / Widowed

If Married, Date of Marriage: ____________________

SPOUSE (INCLUDING SAME SEX SPOUSES, IF LEGALLY MARRIED IN ANOTHER JURISDICTION):

Last Name: _________________________ First Name: ___________________ Middle Initial: _______

Relationship to Employee ______________ Social Sec #: _____-____-_____ Date of Birth: _____________

Address: ____
Street City State Zip Phone #

Is your Spouse Employed? ***Yes or No***

If yes, please provide the following:

Employer Name: ____

Employer Address: ____
Street City State Zip Phone #

Is your Spouse covered under any other health insurance contract, including Medicaid or Medicare? ***Yes or No***

If yes, please provide:

Effective date of coverage: ____________________ Member ID#: ______________________

Carrier Name/Address: ____ Policy #: ________________

Are you required by court order to provide health insurance benefits to your spouse? ***Yes or No***
If yes, please provide a copy of the court order along with this form.

PRESENTATION OF A FALSE STATEMENT IN SUPPORT OF AN APPLICATION FOR HEALTH INSURANCE COVERAGE OR A CLAIM FOR PAYMENT IS PROHIBITED BY SECTION 176.05 OF THE PENAL LAW

____ _______ / _______ / __________

Signature ***Month Day Year***

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

MEMBER ELIGIBILITY VERIFICATION FORM

Complete this form for each dependent and return it with the required documentation to confirm eligibility of your dependent/s.

DEPENDENT INFORMATION:

Dependent Last Name: __________________Dependent First Name: __________________ Middle Initial: _______

Relationship to Employee _____________Dependent Social Sec #: _____-____-_____ Date of Birth: ____________

Dependent Address: ____
Street City State Zip Phone #

Is the dependent married? ***Yes or No*** If yes, marriage date: ____________________

Is the dependent employed? ***Yes or No***

Employer Name: ____

Employer Address: ____
Street City State Zip Phone #

Is the dependent eligible for health insurance from their employer listed above? ***Yes or No***

Is the dependent covered under any other health insurance contract, including Medicaid or Medicare? ***Yes or No***

If yes, please provide:

Effective date of coverage: ____________________ Member ID#: ______________________
Carrier Name/Address: ____ Policy #: ________________

Are you required by court order to provide health insurance benefits to this dependent? ***Yes or No***
If yes, please provide a copy of the court order along with this form.

Is dependent considered handicapped (totally disabled)? ***Yes or No*** Date of dependent's disability ____________

Does this dependent have personal income from any source? ***Yes or No*** ____________________________

Is this dependent claimed on employee's income tax? ***Yes or No*** _________________________________

PRESENTATION OF A FALSE STATEMENT IN SUPPORT OF AN APPLICATION FOR HEALTH INSURANCE COVERAGE OR A CLAIM FOR PAYMENT IS PROHIBITED BY SECTION 176.05 OF THE PENAL LAW

____ _______/_______/__________

Signature ***Month*** ***Day*** ***Year***

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM
MEMBER ELIGIBILITY VERIFICATION FORM

The following lists the required documentation to be provided along with the above form for each family member to be considered for benefit eligibility.

SPOUSE (OPPOSITE SEX AND SAME SEX) – REQUIRED DOCUMENTATION

Government Issued Marriage Certificate (if Married in the Last 12 Months)

OR

*Government Issued Marriage Certificate **AND** Most recent Federal or State Tax Return*

- Your most recent filed Tax Return showing "married filing jointly" OR "married filing separately". Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).
- Only submit page 1 of the return. This could include the 1040 form, e-File Confirmation Page, Tax Preparer's Summary, Federal Return Recap, or Tele-File.
- Mark out all financial information and the first five digits of all Social Security numbers.

OR

*Government Issued Marriage certificate **AND** Proof of Joint Ownership or Residency*

- Submit **BOTH** your marriage certificate and proof of joint ownership or residency. Both the enrollee's and spouse's name must be listed on the documentation of joint ownership or residency and contain recent dates (within the last 6 months). Examples include copy of:
    - Mortgage Statement
    - Homeowners/Renters Insurance Policy
    - Property Tax Document
    - Rental/Lease Agreement
    - Credit Card Statement
    - Loan Obligation
    - Bank Account Statement -

CHILD – NATURAL, ADOPTED, STEPCHILD – REQUIRED DOCUMENTATION

PROOF OF RELATIONSHIP – REQUIRED FOR ALL CHILDREN TO BE CONSIDERED FOR BENEFITS

- BIOLOGICAL CHILDREN < AGE 26
    - Copy of government issued Birth Certificate, containing the child's name, birth date and parents' names.
    - A non-government issued Birth Certificate including the child's name, date of birth, and parents' names may be used if the child is less than 3 months in age.
- ADOPTED CHILDREN < AGE 26
    - Adoption Placement Agreement including the child's date of birth or Petition of Adoption including the child's date of birth.
    - Adoption Certificate, adoption papers, or other official document issued by the U.S. Government, including the child's date of birth.
- ADULT CHILD >26 AND <30 YOUNG ADULT OPTION (NEW YORK STATE MANDATE-7/1/2010)
    - **Proof of dependent residency required – one of the following in the dependent's name**
        - Driver's license,
        - Auto registration
        - Tax return
        - Passport
        - Utility/telephone bill
        - Lease agreement
- HANDICAPPED CHILD
    - Your most recent filed Tax Return listing child as dependent
    - Copy of dependent's last psychological evaluation, WAIS and/or MMPI Report.
    - Form completed and signed by child's attending physician

DOMESTIC PARTNER – REQUIRED DOCUMENTATION

Government Issued Domestic Partner Registry Certificate (if issued in the Last 12 Months)

OR

Government Issued Domestic Partner Registry Certificate ***AND*** *Proof of Joint Ownership or Residency*

- Submit **BOTH** your Domestic Partner Registry Certificate and proof of joint ownership or residency. Both the enrollee's and spouse's name must be listed on the documentation of joint ownership or residency and contain recent dates (within the last 6 months). Examples include copy of:
    - Mortgage Statement
    - Homeowners/Renters Insurance Policy
    - Property Tax Document
    - Rental/Lease Agreement
    - Credit Card Statement
    - Loan Obligation
    - Bank Account Statement

OR

Complete the attached Affidavit of Domestic Partnership

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM
MEMBER ELIGIBILITY VERIFICATION FORM

AFFIDAVIT OF DOMESTIC PARTNERSHIP

EMPLOYER NAME: ____

GROUP NUMBER: ____

Tax Year ___/___/______

We, ________________________ and _________________________ certify the following to be true and accurate.

A. Domestic Partner Certification

We certify that we are domestic partners in accordance with the following criteria and eligible for benefits coverage under a group health benefit plan:

1. Are each eighteen (18) years of age or older.
2. Share a close personal relationship and are responsible for each other's common welfare;
3. Are each other's sole domestic partner and intend to remain so indefinitely,
4. Are not married to anyone nor have had another domestic partner within the prior six months;
5. Are not related by blood closer than would bar marriage in the State of New York;
6. Share the same regular and permanent residence, with the current intent of doing so indefinitely; we affirm that the effective date of this domestic partnership is ________________ and that this domestic partnership has been in existence for a period of _______ consecutive months, at least, prior to the date identified on the affidavit. We understand that documentation will be required;
7. Are jointly financially responsible for "basic living expense", defined as the cost of basic food, shelter, and any other expenses of a domestic partner which the partner qualified because of the domestic partnership. (Note: domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.); and
8. Were mentally competent to consent to contract when our domestic partnership began.
9. We can, upon request, provide evidence of joint responsibility. Joint responsibility may, but need not necessarily, be demonstrated by the existence of three or more of the following:
    a. A domestic partnership agreement;
    b. A joint mortgage or lease;
    c. Designation of his or her partner as a beneficiary for life insurance and retirement contracts;
    d. Designation of his or her partner as primary beneficiary in the Employee's will;
    e. Durable power of attorney for property and health care; and
    f. Joint ownership of motor vehicle, joint checking or joint credit account.

AFFIDAVIT OF DOMESTIC PARTNERSHIP (continued)

We understand that domestic partners are subject to the other eligibility provisions of the benefit plan.

We understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in a circumstance attested to in this affidavit.

We agree to provide written notice to the payroll/personnel representative if there is any change of circumstances attested to in this affidavit within 30 days of the change by filing a statement of Termination of Domestic Partnership.

After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within six months following the filing of a State of Termination of Domestic Partnership with my payroll/personnel representative.

We understand that Domestic Partners are not eligible for continuation of benefits under COBRA.

Our domestic partnership (as defined in this section) has been in existence for at least (6) months prior to the effective date of this affidavit.

We certify, under penalty of perjury, that the foregoing is true and correct. We, the undersigned employee and the Domestic Partner, understand that falsification of information contained in this Affidavit my lead to disciplinary action, up to and including immediate termination of the employee’s employment, and may subject us to civil action to recover any losses, including reasonable attorney’s fees incurred by Group or by its insurance carrier for benefits provided under the Medical Plan.

B. Partner Certification as a Tax-Qualified Dependent

Based on consultations with a tax advisor, I certify that the previously named person whom I am enrolling for coverage **is or is not** (circle one) my legal tax dependent under IRS Section 152. I agree to notify my employer immediately of any change in this tax status. I understand that coverage of the non-employee domestic partner/same sex spouse could result in additional imputed taxable income to the employee, with possible withholding for payroll taxes (including income and social security taxes). I further understand that this coverage carries potential tax implications for the domestic partner/same sex spouse.

I understand that the Greater Tompkins County Municipal Health Insurance Consortium, BlueCross BlueShield, and ProAct are not currently obligated to provide nor do they currently provide me or my employer with tax reporting, with respect to dues or benefits paid under the plan for my Domestic Partner.

AFFIDAVIT OF DOMESTIC PARTNERSHIP (continued)

C. Dependent Child Certification

I certify that my Partner's child or children named below meet the following requirements:

1. A parent-child relationship exists between the child or children and me.
2. The child or children is or are primarily dependent upon me for support.
3. The child or children is or are unmarried and reside(s) in my household and meet(s) the age eligibility requirements for the policy purchased by Group and is (are) dependent on me for at least 50% of his/her (their) support.
4. I assume full responsibility and control, including any and all debt incurred by the child or children.
5. I, or my Partner, have a court-appointed legal relationship with the child or children (i.e., adoption, guardianship, foster child), or my Partner is the biological parent of the child.

Partner's Dependent Children:

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

Last Name ___________________ First Name___________________ MI ___ Date of Birth ___/___/_____

AFFIDAVIT OF DOMESTIC PARTNERSHIP (continued)

I understand that falsely certifying as to a dependent's eligibility or failure to inform my employer when a dependent no longer meets applicable eligibility requirements may result in disciplinary action, up to and including immediate termination of employment.

I affirm the statements made above are true and complete to the best of my knowledge.

______________________________ Signature of Employee	______________________________ Signature of Partner
______________________________ Print Name	______________________________ Print Name
______________________________ Social Security #	______________________________ Social Security #
______________________________ Date	______________________________ Date
Notary Seal:	Notary Seal:

Approved by Employer:

______________________________ By:	______________________________ Date:

____
Print Name

____
Title: