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 Date of Birth: _____

Employee daytime phone #: _____

Employee Mailing Address: _____
Street City State Zip

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

Marital Status (check one): ☐Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

If Married, Date of Marriage: _____

Spouse (Including Same Sex Souses, If Legally Married):

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Employee _____ Social Security #: _____ Date of Birth: _____

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.

Dependent Information:

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

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 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: _____ Phone #: _____

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 _____

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***

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Additional Dependents/ New Dependents:

Employee Information:

Employee Last Name: _____ Employee First Name: _____ Middle Initial: _____

Employee Social Security #: _____ Employee Date of Birth: _____

Employee daytime phone #: _____

Dependent Information:

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

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 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: _____ Phone #: _____

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 _____

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

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 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: _____ Phone #: _____

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 _____

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

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_____ _____ / _____ / _____

Signature ***Month Day Year***

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Required Supporting Documentation List:

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 (Choose 1 Column Below)

Government Issued Marriage Certificate	*Government Issued Marriage Certificate AND Most Recent Federal or State Tax Return*	*Government Issued Marriage Certificate AND Proof of Joint Ownership or Residency*
If Married in the Last 12 months	Your most recent filed Tax Return showing "married filing jointly" **OR** "married filing separately".	Submit **BOTH** your marriage certificate and proof of joint ownership or residency.
	Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).	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).
	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.	**Examples include:** Mortgage Statement Homeowners/ Renters Insurance Policy Property Tax Document Rental/ Lease Agreement Credit Card Statement Loan Obligation Bank Account Statement
	Mark out all financial information and the first five digits of all Social Security numbers.	

Child- Natural, Adopted, Stepchild- Required Documentation

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

Biological Children < Age 26	*Adopted Children < Age 26*	*Handicapped Child*
Copy of government issued Birth Certificate, containing the child's name, birth date and parents' names.	Adoption Placement Agreement including the child's date of birth or Petition of Adoption including the child's date of birth.	Your most recent filed Tax Return listing child as dependent.
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.	Adoption Certificate, adoption papers, or other official documents issued by the U.S. Government, including the child's date of birth.	Copy of the dependent's last psychological evaluation, WAIS and/or MMPI Report.
		Form completed and signed by child's attending physician.

Domestic Partner- Required Documentation (Choose 1 Column Below)

Government Issued Domestic Partner Registry Certificate	*Government Issued Domestic Partner Registry Certificate AND Proof of Joint Ownership or Residency*	*Complete Affidavit of Domestic Partnership*
If issued in the last 12 months.	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 the joint ownership or residency and contain recent dates (within the last 6 months).	
	See Examples above, under Spouse Joint Ownership/ Residency	