

**DEPENDENT VERIFICATION AFFIDAVIT**  
**Washington University in St. Louis**

Medical School Benefits- Campus Box 8002/Fax (314) 362-2500  
 Danforth Benefits- Campus Box 1190/Fax (314) 935-8198

**SEE BACK OF FORM FOR INSTRUCTIONS**

\_\_\_\_\_  
**Employee Name (please print)**

\_\_\_\_\_  
**Employee ID**

Please review the instructions, the definition of Dependents Eligible for Coverage under Washington University's Health/Dental Plan ("the Plan"), and the information on the spouse/domestic partner premium surcharge on the reverse side of this form. Then complete the information below on those dependents that you are currently covering or wish to cover under the Plan. Failure to return this affidavit will result in ineligibility for or loss of health/dental plan coverage for your dependent(s).

**Spouse/Domestic Partner Premium Surcharge**

Is your Spouse or Domestic Partner employed outside of Washington University?

Yes  No

If yes, does your spouse or domestic partner have available health insurance through his/her employer at full-time health premium rates (whether or not they have elected to take it)?

Yes  No

Effective 1/01/2017, Washington University will add an \$80 monthly premium surcharge to the Plan premiums for employees who earn \$45,000 or more annually, are eligible for full-time health premiums, and elect to cover a spouse or domestic partner employed outside of Washington University who is eligible for full-time health premiums through his or her own employer's health insurance plan. The premium surcharge will be deducted on a pre-tax basis for a spouse and on an after-tax basis for a domestic partner, and will be in addition to the applicable WU health premium.

Do you want to cover your Spouse or Domestic Partner under the University's health plan?

Yes  No

**Dependent Eligibility Verification**

Relationship	Gender	Dependent Name/ Date of Birth	Eligible for coverage?	If required, I can provide documents to support this person's eligibility
<input type="checkbox"/> Spouse <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, drop from coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, drop from coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, drop from coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, drop from coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify and warrant to Washington University that all information on this dependent verification affidavit is true, correct and current as of the date signed. I agree to provide supporting documentation upon the request of Washington University. I understand if I knowingly submit false information, my coverage may be terminated and I may be subject to disciplinary action up to and including termination of employment. Please remove any dependent(s) from the health plan that I have indicated above as not eligible for coverage.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

## **Dependent Verification Affidavit Instructions**

Washington University performs an annual dependent eligibility review for its Plan. Please use this DEPENDENT VERIFICATION AFFIDAVIT to list the individuals you currently cover or wish to cover under the Plan as your dependents. The definition of eligible dependents is provided below. Please list each dependent and check the appropriate boxes for each dependent.

The affidavit must be signed and returned in order to have dependent coverage under the Plan. It is important that your responses be accurate as any inconsistencies discovered will be investigated and may result in severe negative consequences. Washington University will terminate coverage on your dependents if you do not respond and/or it is determined that your dependents are not eligible according to the terms of the Plan.

If you find that any or all of your covered dependents do not qualify as eligible dependents under the Plan, you may take this opportunity to request that coverage be terminated. Washington University will not take any disciplinary action based on benefits received for, or information submitted concerning, those ineligible dependents if they are dropped as part of this dependent eligibility review.

Washington University will not assume any liability resulting from terminating coverage of the ineligible dependents. To terminate the coverage of an ineligible dependent, return the enclosed form with the ineligible dependent(s) noted by checking the "No, drop from coverage" box next to their name. Terminated ineligible dependents may be eligible for COBRA continuation coverage if a qualifying event occurred within the last 31 days.

### **Dependents eligible for coverage under the plan are:**

1. Your Spouse or Domestic Partner, who resides with you. A Spouse is the person to whom you are legally married. A Domestic Partner is defined as a person of either gender to whom you are not legally married, but who resides with you in a non-platonic relationship and with whom you have an emotional and financial commitment. You and your Domestic Partner must not be legally married to, or the Domestic Partner of, another person under either statutory or common law.
2. Your (or your spouse/domestic partner's) children (including natural or legally adopted children, stepchildren, children placed with you for adoption, or children for whom you are the legal guardian) from birth to age 26. A child for whom health care coverage is required under a Qualified Medical Child Support Order or other court or administrative order also qualifies as an eligible dependent.
3. Your (or your spouse/domestic partner's) children (including natural or legally adopted children, stepchildren, children placed with you for adoption, or children for whom you are the legal guardian) who are age 26 or older, are dependent upon you for support, and are incapable of self-support due to mental or physical disability, as long as the disability existed prior to the child attaining age 26 and the child was covered as your dependent under the Plan immediately prior to attaining age 26.

### **SUPPORTING DOCUMENTS**

Washington University is entitled to request and you may be required to provide a copy of one or more of the following documents to support your dependents' eligibility:

- marriage certificate or license
- domestic partner verification form
- proof of residence for domestic partner
- divorce decree
- birth certificate
- tax return
- proof of dependent child's continued disability if 26 years of age or older
- final adoption certificate
- legal adoption agency or placement document
- Qualified Medical Child Support Order
- legal document for court-appointed guardianship

### **SPOUSE/DOMESTIC PARTNER PREMIUM SURCHARGE**

Effective January 1, 2016, Washington University will add an \$80 monthly premium surcharge to the Plan premiums for employees with an annual gross income of \$43,000 or more annually who elect to cover a spouse or domestic partner employed outside of Washington University who is eligible for full-time health insurance premiums through his or her own employer's plan. The premium surcharge will be in addition to the applicable WU health premium. Please complete the information on this affidavit relating to your spouse's/domestic partner's employment outside of the University.