WASHINGTON UNIVERSITY HEALTH/DENTAL PLAN
DEPENDENT VERIFICATION AFFIDAVIT
Clinical Fellows, Postdoctoral Research Appointees and Union Employees

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

Name (please print) _____ **WUSTL ID** _____

Please review the instructions, the definition of Dependents Eligible for Coverage under Washington University's Health/Dental Plan ("the Plan") 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).

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
☐ Spouse ☐ Ex-Spouse ☐ Domestic Partner	☐ Male ☐ Female		☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
☐ Child	☐ Male ☐ Female		☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
☐ Child	☐ Male ☐ Female		☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
☐ Child	☐ Male ☐ Female		☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
☐ Child	☐ Male ☐ Female		☐ Yes ☐ No, drop from coverage	☐ Yes ☐ 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**.**

_____ _____

Clinical Fellow, Postdoc Appointee, Union 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