

**Tompkins County**  
**PERSONNEL DEPARTMENT**

125 East Court Street  
Ithaca, New York 14850-4284  
(607) 274-5526

**Member Eligibility  
Verification Form**

CSEA WC, CSEA BC, Corrections,  
Confidential, Management, Public  
Library employees, all County  
retirees (County, TC3, Library)

**SUBSCRIBER INFORMATION:**

Employee Last Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Employee First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Employee Social Security #: \_\_\_\_\_ Employee Date of Birth: \_\_\_\_\_

Employee Mailing Address:

\_\_\_\_\_ street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code

Employee Home Address:

\_\_\_\_\_ street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code

Contact number \_\_\_\_\_

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

If Married, Date of Marriage: \_\_\_\_\_

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

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address:

\_\_\_\_\_ street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code

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 #: \_\_\_\_\_

Complete this form for each dependent and return it with the required documentation to confirm eligibility of your dependents. Please use additional forms if needed.

**DEPENDENT INFORMATION - 1: (IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE COPY THIS PAGE)**

Dependent Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Dependent Social Security #: \_\_\_\_\_

Dependent Address: \_\_\_\_\_  
street city state zip code

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 #: \_\_\_\_\_

Is dependent considered disabled? Temporary/Permanent? (circle one) ***Yes or No***

Date of dependent's disability \_\_\_\_\_

**DEPENDENT INFORMATION - 2:**

Dependent Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Dependent Social Security #: \_\_\_\_\_

Dependent Address: \_\_\_\_\_  
street city state zip code

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 #: \_\_\_\_\_

Is dependent considered disabled? Temporary/Permanent? (circle one) ***Yes or No***

Date of dependent's disability \_\_\_\_\_

***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***

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

The following is a list of required documentation to be provided with your completed information 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 (if Married more than 12 Months)**

- 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.
- Your documents will be reviewed and returned to you.

## **REQUIRED DOCUMENTATION**

### **Child – Natural, Adopted, Stepchild**

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.

### **Step Children < age 26**

The stepchildren of the subscriber are eligible for coverage as of the date the subscriber marries the child's parent. Coverage is effective on the date of marriage, as long as the subscriber applies for coverage within 30 days of the marriage.

- A copy of the child's Birth Certificate and a copy of the marriage license to establish the relationship to the subscriber as stepparent

### **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.

### **Guardianship < age 26**

A child for whom the subscriber is the legal guardian and who is chiefly dependent upon the subscriber for support is eligible. Custody alone is not sufficient. A court must specifically confer legal guardianship.

- A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship.
- Proof of financial dependency.

### **Adult Child >26 and <30 Young Adult Option (New York State Mandate-7/1/2010)**

Young adult Option Outline: under the age of 30, dependent child, residency with parent not required, NYS residency required, cannot be married, student status is not required.

Proof of dependent residency required – one of the following in the dependent's name

- Driver's license
- Tax return
- Utility/telephone bill
- Lease/rental agreement

## **Disabled Child**

A child who is incapable of self-sustaining employment may be eligible to continue coverage beyond the age where coverage would otherwise terminate. One of the following conditions must cause the incapacity:

- Mental illness
- Developmental disability as defined in the NYS Mental Hygiene Law
- Physical disability

### **The child must also meet the following conditions:**

- The condition occurred before the dependent reached the maximum age under the certificate
- The child was covered at the time he or she would have otherwise reached the maximum age under the certificate
- The condition continues to exist
- The child remains unmarried
- The child remains dependent upon the subscriber for support

A Medical Director from Excellus BlueCross BlueShield reviews all applications for coverage for a disabled dependent. The Medical Director will determine whether the condition is permanent or temporary. If the condition is temporary, Excellus will periodically request the recertification of the dependent's eligibility, through the submission of a new disabled dependent form.

## **REQUIRED DOCUMENTATION**

### **Domestic Partner**

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

**OR**

**Government Issued Domestic Partner Registry Certificate AND Proof of Co-habitation/Residency**

Submit BOTH your Domestic Partner Registry Certificate and proof of co-habitation/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

**OR**

**Complete the attached Affidavit of Domestic Partnership**

## 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 insurance 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 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 provide evidence of joint responsibility. Joint responsibility is to 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 may 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, Medical Insurance vendor and Pharmacy Benefits Manager 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)**

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 : \_\_\_\_\_

Print Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Notary Seal:**

Signature of Domestic Partner: \_\_\_\_\_

Print Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Notary Seal:**

Approved by Employer:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

## **Appeal Process**

When the County determines there is insufficient documentation provided to support the relationship between a spouse/dependent on the employee's health insurance employees will be given written notice in advance of the effective date of removal, and the reasons the documentation provided was insufficient.

To appeal the determination:

Step 1: The employee may submit a written appeal to the County Attorney, with a copy to the Union President within ten (10) calendar days of the date of the notice of removal. The County Attorney will respond writing to member and Union of his or her determination within ten (10) days of receipt of the written appeal.

Step 2: If the issue is not resolved to the employee and Union's satisfaction the employees whose dependents, including spouse, who are found to be ineligible for coverage under the employer's health insurance plan may then file a grievance within ten (10) days under Step 2 of the grievance procedure of the Collective Bargaining Agreement.

At such Step 2 meeting each party shall be entitled to bring in additional persons who are qualified to review such documentation.

Step 2 shall consist solely of a review of all documents submitted by the employee including but not limited to any written explanation or affidavits addressing reason why the employee asserts the dependent is eligible. The dependents of employees who submit a timely appeal of ineligibility determination, shall not have their coverage terminated while the Step 2 appeal is pending.

Step 3: If the decision in Step 2 is unacceptable to the aggrieved party, the Association may submit the matter to arbitration by submitting a request for a hearing to arbitration, with a copy to the Commissioner of Personnel within ten (10) days of the Step 2 decision.

Both parties may strike a panel member at any time and the parties may agree upon a replacement arbitrator. There shall be no more than three (3) arbitrators on the panel. If at least one panel member does not remain, arbitrations shall be conducted under the rules of the Public Employment Relations Board until such time as the parties can agree on a panel of members. The issue before the arbitrator shall be limited solely to determining if the documentation supplied was sufficient to document the relationship as required by the Tompkins County Health Insurance Consortium. The arbitrator's decision shall be binding. The cost of such Hearing Officer shall be shared equally between the parties.