Tompkins County
Human Resources
125 E. Court St.
Ithaca, NY 14850
(607) 274-5526

Dependent Eligibility Verification Form

CSEA WC, CSEA BC, Corrections, Confidential, Management, Public Library Employees, all County Retirees (County, TC3, Library)

Complete this form if you are enrolling any dependents (spouse, domestic partner, children), and for each dependent listed please attach the required documentation to confirm eligibility of your dependents. Use additional forms if needed.

SUBSCRIBER:

Employee Name *(Last, First, MI)*: _____

Employee SSN: _____ Employee DOB: _____ Employee ID #: _____

Employee Mailing Address:

_____
Street City State Zip Code

Employee Home Address:

_____
Street City State Zip Code

Phone Number: _____

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

If Married, Date of Marriage: _____

SPOUSE OR DOMESTIC PARTNER:

Spouse/DP Name *(Last, First, MI)*: _____

Spouse/DP Social Security #:_____ Spouse/DP Date of Birth: _____

Spouse/DP Address:

_____
Street City State Zip Code

Phone Number: _____

DEPENDENT 1:

Dependent Name *(Last, First, MI)*: _____

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

Relationship to Employee: _____

Dependent Address:

_____
Street City State Zip Code

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

Date of Dependent's Disability: _____

DEPENDENT 2:

Dependent Name *(Last, First, MI)*: _____

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

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

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

Date of Dependent's Disability: _____

DEPENDENT 3:

Dependent Name *(Last, First, MI)*: _____

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

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

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

Date of Dependent's Disability: _____

DEPENDENT4:

Dependent Name *(Last, First, MI)*: _____

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

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

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

Date of Dependent's Disability: _____

Are you or any dependents covered under any other health insurance that will be kept while enrolled in coverage through Tompkins County, including Medicaid or Medicare? *Yes or No* (Circle One) If yes, please provide:

Name (Employee and/or Dependent)	***Insurance Carrier***	***Group #***	***Member ID #***	***Effective Date***

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 – 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 Longer 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 copied and originals returned to you.

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 Co-habitation/Residency (If Issued More Than 12 Months Ago)

Submit BOTH your Domestic Partner Registry Certificate and proof of co-habitation/residency. Both the enrollee's and domestic partner'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

You may need to also file a Tompkins County Domestic Partner Affidavit for Tax Implications on Employee Benefit Plans if your Domestic Partner is considered your dependent under Internal Revenue Code Section 152. Please see Domestic Partner Benefit summary for details on tax implications regarding Domestic Partnerships and Benefits.

Child (Natural, Adopted, Stepchild) – Required Documentation
Proof of relationship is 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 under 3 months of age.

Step-Children < Age 26
The step-children of the subscriber are eligible for coverage as of the date the subscriber marries the child's parent. Please provide:

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

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. This could be an 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. Please provide the following:

- 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 Adult Child
A child who is incapable of self-sustaining employment may be eligible to continue coverage beyond the age where coverage would otherwise terminate in the case of mental illness, developmental disability as defined by NYS Mental Hygiene Law, and/or 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.

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.