Chaffey College

Office of Human Resources

Employee Name (printed)

DEPENDENT(S) VERIFICATION ELIGIBILITY

Your dependents include your lawful spouse or registered domestic partner and your eligible children or **dependent** grandchildren (dependent of a dependent) **as defined below**. Monthly coverage is effective only if the eligibility criterion continues to be met.

	Dependents	Eligibility
1.	**Spouse**	Legal husband or wife.
2.	**Domestic Partner**	Have filed a Declaration of Domestic Partnership and registered with the State of California.
3.	**Child** (Son, daughter, step-son, step-daughter, adopted son, adopted daughter, or children placed with you for adoption). Foster children are not covered.	Your or your spouse's eligible children as specified on the left who are under the age of 26.
4.	**Dependent of a Dependent-CSEA Only & Kaiser Only**	Children whose parent is a Dependent under your family coverage (including adopted children or children placed with your Dependent for adoption, but not including foster children) if they are under age 26. The child will only be covered while the eligible Dependent is covered.
5.	**Legal Guardianship-CSEA Only**	Children (not including foster children) for whom you or your Spouse is the court appointed legal guardian (or was when the person reached age 18) if they are under the age 26.
6.	**Parent/Child Relationship-CalPERS Medical Subscribers Only**	Contact Human Resources for eligibility.

Relationship	First Name	Last Name	Date of Birth

I understand that all individuals added to any group insurance plan must continue to meet the dependent eligibility requirements shown above at all times, dependents must be added within 30 days from the date of my eligibility for coverage, or added within 30 days from the date of a qualifying event (i.e., marriage, registration of domestic partnership, birth, adoption, etc.). I further understand that the District requires proof of eligibility—certified marriage or birth certificate, certification of domestic partnership, adoption papers, etc.

I understand that insurance coverage will terminate on the first day of the month following the date that eligibility is no longer met (i.e., divorce, termination of domestic partnership, death, maximum age limit reached, etc.). I further understand that it is my responsibility to inform the office of human resources within 30 days from the date in which a dependent no longer qualifies to continue on the District benefit plans, i.e. divorce.

I understand that I have the responsibility to notify the Office of Human Resources, using the appropriate forms, of any family status change that affects eligibility for coverage.

I CERTIFY UNDER PENALTY OF PERJURY THAT THE DEPENDENTS SHOWN ABOVE ARE CORRECT, AND MEET ALL OF THE REQUIREMENTS FOR COVERAGE ON MY INSURANCE PLAN(S).

Employee's signature _____ **Datatel ID #** _____ **Date** _____