



Member Eligibility Verification Form

Road Patrol

EMPLOYEE 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

Employee Home Address: _____
(If different) Street City State Zip

Employee day time phone #: _____

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: _____

Relationship to Employee _____ Social Sec #: _____ - _____ - _____

Address: _____
Street City State Zip

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 #: _____

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

____ / ____ / ____
Month Day Year

The following lists the required documentation to be provided along with the above form for each family member to be considered for benefit eligibility.

SPOUSE (OPPOSITE SEX AND SAME SEX) – REQUIRED DOCUMENTATION

Government Issued Marriage Certificate

All other documentation required is now removed.

CHILD – NATURAL, ADOPTED, STEPCHILD – REQUIRED DOCUMENTATION

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 and birth date. Name of only one parent needed to establish the relationship to the subscriber.
- A non-government issued Birth Certificate including the child's name and birth date may be used if the child is less than 3 months in age. Name of only one parent needed to establish the relationship to the subscriber.

- **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. Name of only one parent needed to establish the relationship to the subscriber.

- **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.

ALL IRRELEVANT PERSONAL AND FINANCIAL INFORMATION IN THE DOCUMENTS SHOULD BE REDACTED

- **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.

ALL IRRELEVANT PERSONAL AND FINANCIAL INFORMATION IN THE DOCUMENTS SHOULD BE REDACTED

- **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

ALL IRRELEVANT PERSONAL AND FINANCIAL INFORMATION IN THE DOCUMENTS SHOULD BE REDACTED

- **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.

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*

- 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

All irrelevant financial information contained in the documents above can and should be redacted.

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 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 regular and 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

Signature of Partner

Print Name

Print Name

Social Security #

Social Security #

Date

Date

Notary Seal:

Notary Seal:

Approved by Employer:

By:

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. If the Association submits a timely request for arbitration, the dependents of employees shall not have their coverage terminated while the Step 3 arbitration is pending.

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.