CITY OF SCOTTSDALE

CITY OF SCOTTSDALE HEALTH/DENTAL PLAN
DEPENDENT VERIFICATION AFFIDAVIT

______________________________ ______________

Employee Name (please print) **Employee ID**

Please review the instructions, the definition of Dependents Eligible for Coverage under the Plan and the dependents you have covered under the current Plan.. Then complete the information below on those dependents that you are currently covering 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 Name/ Date of Birth	Gender	Relationship	Eligible for coverage?	If required, I can provide a copy of the legal documents to support this person's eligibility
	☐ Male ☐ Female	☐ Spouse ☐ Ex-Spouse ☐ Domestic Partner	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
	☐ Male ☐ Female	☐ Child ☐ Legal Guardianship Child ☐ Domestic Partner Child	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
	☐ Male ☐ Female	☐ Child ☐ Legal Guardianship Child ☐ Domestic Partner Child	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
	☐ Male ☐ Female	☐ Child ☐ Legal Guardianship Child ☐ Domestic Partner Child	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
	☐ Male ☐ Female	☐ Child ☐ Legal Guardianship Child ☐ Domestic Partner Child	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No
	☐ Male ☐ Female	☐ Child ☐ Legal Guardianship Child ☐ Domestic Partner Child	☐ Yes ☐ No, drop from coverage	☐ Yes ☐ No

By my signature on this affidavit, I certify and warrant to City of Scottsdale that all information on this dependent verification affidavit is true, correct as of the date signed. I agree to provide supporting documentation upon the request of City of Scottsdale. 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.

______________________________ ______________

Employee Signature Date

DEPENDENT VERIFICATION AFFIDAVIT INSTRUCTIONS

The City of Scottsdale performs an annual dependent eligibility review for the medical and dental plans offered to employees (collectively "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 box(es) 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. The City of Scottsdale 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. The City of Scottsdale 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 legal spouse or domestic partner for whom you can supply relevant documentation.
2. Your (or your spouse's/domestic partner's) children (including natural children, stepchildren, legally adopted children, or children placed with you for adoption, or for whom you are the legal guardian) from birth to 26 years of age.. 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 a dependent.
3. Your (or your spouse's/domestic partner's) unmarried children (including natural children, stepchildren, legally adopted children, or children placed with you for adoption, or for whom you are the legal guardian), who are 26 years of age or older, are dependent upon you for support, and are incapable of self support due to mental or physical disability.

DOCUMENTS TO SUPPORT DEPENDENT ELIGIBILITY

The City of Scottsdale 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
- Divorce decree/termination of Domestic Partner relationship
- Final adoption certificate
- Qualified Medical Child Support Order
- Birth certificate/hospital issued certificate
- Tax returns
- Legal adoption agency or placement document
- Proof of dependent child's continued disability
- Domestic Partner affidavit & supporting documentation