MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
Benefits Department

Montana University System – Employee Benefits

Declaration of Adult Dependent

Employee Name_____ Social Security#_____

Employing Campus_____

Please specify the requested information for your eligible Adult Dependent:

Name_____

DOB_____

SSN_____

Eligibility

As an employee of the Montana University System who is eligible for medical insurance coverage, I certify that the above identified person meets the following criteria for an eligible Adult Dependent in accordance with the Plan's Supplemental Plan Document pages 1-4. (Documentation demonstrating the criteria is attached):

- ☐ Is at least 18 years of age;
- ☐ Has proof of joint ownership or joint tenancy with the Subscriber for at least the most recent six (6) consecutive months;
- ☐ Does not meet the legal definition of spouse or the Plan's definition of dependent child;
- ☐ Is ineligible for any other comparable group insurance coverage;
- ☐ Does not have a parental relationship with the Subscriber, and is not otherwise related to the Subscriber by blood or marriage;
- ☐ Has a financially-interdependent relationship with the Subscriber as evidenced by at least **two** (2) of the following conditions:
  - ☐ Joint ownership or lease of a residence;
  - ☐ At least two of the following:
    - ☐ Joint bank account
    - ☐ Joint billing statements (residential utilities or phone)
    - ☐ Joint credit card accounts
    - ☐ Joint loan agreements
    - ☐ Joint car ownership
    - ☐ Other titles or deeds that are jointly owned
  - ☐ Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
  - ☐ Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities.

An Eligible Dependent does not include a spouse who is currently legally separated or divorced from the Subscriber and has a court order or decree stating such from a court of competent jurisdiction.

Notification of Change in or Termination of Dependent Relationship

I agree, that, if the dependent relationship as designated above, no longer exists, I will notify the Montana University System in a manner set forth by the employing campus within 30 days of such change.

Certification

I understand all of the following:

1. The eligibility and coverage of dependent will cease at the end of the month in which any of the above-defined criteria are no longer met:
2. Under federal and state law, benefit coverage of certain dependents described above may result in taxable income to the employee and is subject to income tax withholding and applicable payroll taxes;
3. Coverage for eligible dependents may only be activated during open enrollment or if a qualifying change in dependent or job status occurs during the plan year;
4. Montana University System must be given written notice within thirty (30) days of any change in circumstances attested to in this document;
5. Falsely certifying eligibility for dependent coverage or failing to inform Montana University System of a relevant change in eligibility requirements in any respect may result in disciplinary action against the employee;
6. The employee will be liable for all expenditures for coverage and benefits obtained because of any misrepresentation or omission in certifying eligibility for benefits or in failing to inform Montana University System of a change in eligibility criteria.

I further understand and acknowledge that the Montana University System reserves the right to require copies of any or all of the above-listed documents. If I fail to provide the copies when requested, I understand that medical insurance coverage for the named dependent will be immediately terminated.

I affirm that the assertions made herein are true and correct to the best of my knowledge.

_____

Employee Signature Date

AFFIRMATION

State of_____)

: ss.

County of_____)

On this_____ day, of _____, 20____ , before me, a notary public, personally appeared _____ , who made known to me to be the person who executed the within affirmation and acknowledged to me that he/she executed the same for the purposes therein stated.

(seal)

_____

Signature of Notary Public

_____

Printed Name

Residing at_____

My Commission Expires:_____

***Submit completed form to your campus Human Resources/Benefits office within 63 days of the date of affirmation. Coverage begins the first of the month following receipt of the completed form. If not received within 63 days of the date of affirmation, the Adult Dependent will not be eligible for coverage without a Qualifying Event. See the Summary Plan Description for additional information.