

Dependent Eligibility Verification Checklist

Employee Name: _____

Dependent Name(s) **AND** Dependent Type(s): _____

Employees and departmental human resources staff are required to complete this form when adding dependents to health or dental coverage, as well as vision coverage processed through departmental Human Resources offices, and when an employee annually recertifies their parent-child relationship with enrolled dependents. By completing this form, employees are certifying the information is accurate and staff are certifying they have received supporting documentation to verify dependent eligibility.

The following chart defines the dependents eligible for health, dental, and premier vision plan coverage and acceptable documents to verify respective eligibility. Departmental human resources staff must use this form to indicate which documents were provided by the employee to determine their dependent(s) eligibility.

Section 1—Required and Acceptable Forms and Documents for Determining Dependent Eligibility

Dependent Type	Required Enrollment Forms	Acceptable Document(s) to Verify Eligibility
Spouse/Registered Domestic Partner	<p><u>Health</u></p> <p><input type="checkbox"/> Health Benefit Plan Enrollment Form (HBD-12)</p> <p><input type="checkbox"/> Declaration of Health Coverage (HBD-12A)</p> <p><u>Dental</u></p> <p><input type="checkbox"/> Dental Plan Enrollment Authorization (STD. 692)</p> <p><u>Vision</u></p> <p><input type="checkbox"/> Premier Vision Plan Enrollment Authorization (CalHR 774)</p>	<p><input type="checkbox"/> Marriage Certificate/Declaration of Domestic Partnership or Certificate of Registry of Marriage (Certificate of Registry of Marriage must be issued within the <u>last</u> 6 months); or,</p> <p><input type="checkbox"/> Affidavit of Marriage/Domestic Partnership (CalPERS Form HBSD-1965)</p> <p><i>If date of marriage/registration is more than 60 days past, must also provide:</i></p> <p><input type="checkbox"/> Copy of front page of most recent federal or state tax return (confirming dependent as spouse)</p> <p>OR</p> <p>A document dated within the last 60 days showing current relationship status (document must list employee’s name, spouse’s name, address, and date), such as:</p> <p><input type="checkbox"/> Household bill or statement of account; or,</p> <p><input type="checkbox"/> Other (e.g., life or auto insurance policy):</p> <p>_____</p>
Children (natural-born, adopted, placement for adoption, step, or registered domestic partner’s children) up to age 26 (the month in which dependent attains age 26)	<p><u>Health</u></p> <p><input type="checkbox"/> Health Benefit Plan Enrollment (HBD-12)</p> <p><input type="checkbox"/> Declaration of Health Coverage (HBD-12A)</p> <p><u>Dental</u></p> <p><input type="checkbox"/> Dental Plan Enrollment Authorization (STD. 692)</p> <p><u>Vision</u></p> <p><input type="checkbox"/> Premier Vision Plan Enrollment Authorization (CalHR 774)</p>	<p><input type="checkbox"/> Birth Certificate; or,</p> <p><input type="checkbox"/> Official Hospital Birth Record (e.g., Certificate of Live Birth); or,</p> <p><input type="checkbox"/> Adoption Certificate naming employee, spouse, or domestic partner, as the child’s parent; or,</p> <p><input type="checkbox"/> Court order naming employee, spouse, or domestic partner, as the child’s legal guardian.</p>

Dependent Type	Required Enrollment Forms	Acceptable Document(s) to Verify Eligibility
Disabled Adult Children of any age (must be disabled and enrolled prior to age 26)	<p><u>Health</u></p> <input type="checkbox"/> Health Benefit Plan Enrollment (HBD-12) <p><u>Dental</u></p> <input type="checkbox"/> Dental Plan Enrollment Authorization (STD. 692) <p><u>Vision</u></p> <input type="checkbox"/> Premier Vision Plan Enrollment Authorization (CalHR 774) <p>AND</p> <input type="checkbox"/> Member Questionnaire for Disabled Dependent (HBD-98) <input type="checkbox"/> Medical Report for Disabled Dependent (HBD-34)	Follow certification process for disabled dependents in accordance with CalPERS Circular Letter #600-045-12.
Children up to age 26 for whom the employee assumes a Parent-Child Relationship (PCR) in-lieu of the parent by: <ul style="list-style-type: none"> • assumption of parental status; or, • assumption of parental duties <p><i>*Note: The departmental HR representative determines if a "parent-child relationship" exists as evidenced by the assumption of parental status or duties and documents provided by the employee to substantiate their relationship with the dependent.</i></p>	<p><u>Health</u></p> <input type="checkbox"/> Health Benefit Plan Enrollment (HBD-12) <input type="checkbox"/> Declaration of Health Coverage (HBD-12A) <input type="checkbox"/> Affidavit of Parent-Child Relationship (HBD-40) <p><u>Dental</u></p> <input type="checkbox"/> Dental Plan Enrollment Authorization (STD. 692) <input type="checkbox"/> Dental Affidavit of Eligibility (CalHR 025) <p><u>Vision</u></p> <input type="checkbox"/> Premier Vision Plan Enrollment Authorization (CalHR 774)	Documents demonstrate employee has assumed a parent-child relationship in-lieu of the parent, such as: <ul style="list-style-type: none"> <input type="checkbox"/> Copy of front page of most recent federal or state tax return; or, <input type="checkbox"/> Court order naming employee as child's legal guardian; or, <input type="checkbox"/> Day care receipts or school records indicating child resides at employee's current address; or, <input type="checkbox"/> Other (e.g., tuition payments, auto insurance policy): <hr/> <hr/>
Recertification of Parent-Child Relationship Note: Employee must submit a signed and dated Affidavit of Parent-Child Relationship and supporting documentation <u>annually</u> to demonstrate a current parent-child relationship with enrolled dependent(s).	<p><u>Health</u></p> <input type="checkbox"/> Affidavit of Parent-Child Relationship (HBD-40) for each dependent <p><u>Dental</u></p> <input type="checkbox"/> Dental Plan Enrollment Authorization (STD. 692) <input type="checkbox"/> Dental Affidavit of Eligibility (CalHR 025) <p><u>Vision</u></p> <input type="checkbox"/> Premier Vision Plan Enrollment Authorization (CalHR 774)	Document confirming child is employee's dependent, such as: <ul style="list-style-type: none"> <input type="checkbox"/> Copy of front page of most recent federal or state tax return; or, <input type="checkbox"/> Court order naming employee as the child's legal guardian; or, <input type="checkbox"/> Day care receipts or school records indicating child resides at the employee's current address; or, <input type="checkbox"/> Other (e.g., tuition payments, auto insurance policy): <hr/> <hr/>

Section 2— Acknowledgement of Employee Obligations

To be completed by employee (must initial all):

I hereby certify under penalty of perjury:

- I understand the eligibility requirements described in this document and that all information provided by me is true and correct to the best of my knowledge.
- I provided the required documentation to substantiate the relationship of my enrolled dependent(s).
- I understand that additional information and supporting documentation may be requested as necessary to substantiate dependent eligibility for health, dental, and/or vision benefits.
- I agree to notify my departmental Human Resources office in writing within 60 days upon the dissolution of a marriage or domestic partnership, when a parent-child relationship ceases, or a change in dependent(s) eligibility occurs.
- I understand that making, or causing to be made, any knowingly false material statement or material representation or knowingly failing to disclose a material fact (e.g., divorce), or to otherwise provide false information with the intent to use it, may result in possible employment action up to and including termination of employment.
- I agree that I may be required to reimburse my employer, the health, dental, or vision benefit plan, and the CalPERS for expenditures made for medical claims, processing fees, administrative expenses, and attorney's fees on behalf of any family member, if any of the submitted documentation is found to be inaccurate or fraudulent and that a review of eligibility can occur at any time.

Employee Signature

Date

Section 3— Certification by Human Resources Staff

To be completed by Department/Agency (must initial all):

I hereby certify that:

- I am a duly appointed and qualified representative of the agency/department named below.
- I have reviewed employee's health, dental, and/or vision enrollment form(s) and supporting documents to verify their dependent(s) eligibility.
- I informed employee that they are required to notify their employer in writing within 60 days upon the dissolution of a marriage or domestic partnership, when a parent-child relationship ceases, or a change in dependent(s) eligibility occurs.
- I informed employee that they may be required to reimburse their employer, the health, dental, or vision benefit plan, and CalPERS for expenditures made for medical claims, processing fees, administrative expenses, and attorney's fees on behalf of any family member, if any of the submitted documentation is found to be inaccurate or fraudulent and that a review of eligibility can occur at any time.
- I retained copies of the employee's health, dental, and vision enrollment form(s) and all supporting documents to verify eligibility of employee dependent(s) in the employee's Official Personnel File.
- I will provide a copy of this completed Checklist to the employee.
- Based on the information provided and review of the documentation, I am approving the enrollment of such dependent(s).

HR Representative Name/Title

HR Representative Signature

Date