INDIANA UNIVERSITY

AFFIDAVIT OF ELIGIBLE SPOUSE/DEPENDENT STATUS

FOR IU-SPONSORED HEALTHCARE PLANS

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM

This form is to be used in cases where you do not have possession of or access to any document that verifies your marriage or birth relationship to a spouse or dependent. For example: when actual source documents have been destroyed by fire or other disaster. Unless there are extenuating circumstances, the university does not consider documents inaccessible when they are available through public agencies such as the courts or through a state health department.

Dependents that are eligible for medical and dental care coverage are:

- Your spouse by marriage, either opposite-sex or same-sex, legally entered into in one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country; and
- Children who meet all of the following criteria:
  1. The child is age 25 or under (eligibility ends at the end of the month the child reaches age 26) or qualifies for Disabled Child Eligibility; and
  2. The child has one of the following relationships to you or spouse:
     - biological child; or
     - lawfully adopted child; or
     - your stepchild; or
     - a child for whom you or spouse has been legally appointed sole guardian for an indefinite period of time; or
     - a child you are legally required to provide healthcare coverage for under a Qualified Medical Support Order, as defined by ERISA or an applicable Indiana state law.

Supporting documentation showing that an individual is a qualified dependent (marriage or birth certificate, guardianship orders, as applicable) is required at the time of initial enrollment and periodically thereafter. Failure to provide proof of eligibility within 30 days of the university's written request for such proof may result in termination of health plan coverage.

SECTION 1—EMPLOYEE INFORMATION	
Employee Name:	University 10-Digit ID:
Campus:	Phone:
Email:	

SECTION 2—SPOUSE'S INFORMATION

I attest that I do not have documentation in my possession, at home, or elsewhere, to verify my relationship to the following individual; and that the individual listed below is (A) my spouse as recognized by a legally binding marriage as defined by Indiana law or as certified by the government in the foreign country of my marriage; and that this marriage has not been ended by divorce.

Spouse's Name:	Date of Birth:
Social Security Number[1]:	Relationship:
U.S. State or Foreign Country in which the marriage was performed:	
Is the marriage a legally recognized marriage in this State or County? ☐ Yes ☐ No	
The institution or entity that performed the marriage:	

[1] *If your spouse is a foreign national who is not eligible for a Social Security Number due to a non-working visa, list their ITIN number. If they do not yet have an ITIN number, write the visa type (J2, F2, or H4) in the box to indicate that this person is not eligible for a Social Security Number. Report your spouse's ITIN number to Human Resources as soon as it is available.*

(CONTINUED ON NEXT PAGE)

SECTION 3—DEPENDENT CHILD INFORMATION

I attest that I do not have documentation in my possession, at home, or elsewhere, to verify my relationship to the following individual; and that the individual listed below meets Indiana University's dependent eligibility requirements for coverage as my dependent.

Name	Date of Birth	Social Security Number[2]	Relationship

[2] *If your dependent is a foreign national who is not eligible for a Social Security Number due to a non-working visa, list their ITIN number. If they do not yet have an ITIN number, write the visa type (J2, F2, or H4) in the box to indicate that this person is not eligible for a Social Security Number. Report your spouse's ITIN number to Human Resources as soon as it is available.*

SECTION 4—EXPLANATION

Documentation to verify the marriage or birth relationship of the listed individuals to the employee is not available for the following reason:

SECTION 5—EMPLOYEE CERTIFICATION

By signing this form you are certifying that:

- you have read and understand the University's health plan eligibility guidelines;
- that the above listed spouse is your legal spouse as defined by the State of Indiana or by the government of the foreign country in which the marriage took place, and has not been ended by divorce;
- that the information supplied on this form is true and complete and that any false information or statements made on this form will be grounds for IU to void your coverage and/or terminate your employment;
- you understand your responsibility to notify the University in writing within 30 days of a divorce from your spouse (a spouse is ineligible for health plan coverage as of the date of the divorce); likewise provide notice that a child is no longer your dependent.
- you understand that enrolling an individual that is not your legal spouse/child or failing to provide notice of ineligibility can result in retroactive termination of health care coverage for you and the enrolled spouse (coverage will end on the date the spouseor child was no longer eligible regardless of when notice was given to the University); and
- that such retroactive termination will result in liability on your part for any claim or premium costs paid by the health Plan retroactive to the date the individual was ineligible for coverage.

Employee Signature:	**Date:**

To sign and submit this form digitally you must first save it to your device.

This form can also be emailed to askhr@iu.edu; or mailed to IU Human Resources, 2709 E. 10th Street, Ste 321, Bloomington, IN 47408.