Dependent Verification

As part of our continuing effort to control the rising healthcare costs, NIHIP is ensuring that every dependent enrolled in the NIHIP plans have supplied their Benefit Administrator or Human Resource Department with the appropriate proof documents prior to being enrolled into any of the NIHIP plans. **The dependent proof process is mandatory**!

Upon enrolling new hires electing dependent coverage (Spouse or Children) **OR** any life event changes adding dependents on the plan, employees need to supply the appropriate proof documents for their dependents to qualify for coverage.

The table below details which documents are required.

Qualified Dependents	Acceptable Proof Documents
Spouse (Traditional Marriage or Civil Union)	• Marriage Certificate or Civil Union Certificate
Child(ren) – Biological	• Legal Birth Certificate
Child(ren) - Adopted	• Initial Stage – Official Court/agency papers • Mid-Stage – Official Court Adoption Agreement • Final Stage – Birth Certificate
Stepchild(ren)	• Child's Birth Certificate showing the child's parent is the employee's spouse. • Marriage Certificate showing legal marriage between the employee and the child's parent. • Court Document showing that your spouse has custody of the child or is required to cover the child • Affidavit showing proof of the step parent's name being added to the Birth Certificate
Other Child (Legal Guardian)	• Court papers naming the employee as the legal guardian
Child Court-Ordered Medical Coverage	• Qualified Medical Child Support (QMCSO) • National Medical Support Notice (NMSN)
Child Age 26 or Older	• Certified Handicapped Child/Disabled Student Attending Physician Statement signed by the employee and the child's attending Physician • DD-214 Military document showing honorable discharged from military branches (Air Force, Army, Marine Corps, Navy)

Dependent Verification

NIHIP Dependent Coverage Questionnaire

Employees applying for dependent coverage must complete the following information and return to their District Administrator or Business Office within 31 days of your hire date or the date of an eligible change in coverage is requested. Failure to timely return this form with appropriate documentation will result in the loss of the ability to enroll your dependents for health coverage until you are next entitled to do so.

Employee Information

Last Name:_____ First Name:_____ Date of Birth:_____

Street Address:_____ City_____ State_____ ZIP_____

Job Title:_____ Hire Date:_____ District Name:_____

Dependent Information (*supporting documentation required*)

Employee's Marital Status: □ **Single** □ **Married** □ **Separated** □ **Divorced** □ **Widowed**

Is your spouse a Civil Union Partnership? □ **Yes** □ **No** Do you have a Civil Union Certificate? □ **Yes** □ **No**

Is your spouse a Domestic Partnership? □ **Yes** □ **No** Do you have a Domestic Partner Affidavit? □ **Yes** □ **No**

Spouse:

Last Name: (if different) _____ First Name: _____ Date of Birth: _____

Street Address: (if different) _____ City _____ State_____ Zip_____

Employer Name: _____ Hire Date: _____

Child(ren):

(Child 1) Last Name: (if different) _____ First Name: _____ Date of Birth: _____

Street Address: (if different) _____ City _____ State_____ Zip_____

Employer Name: _____ Hire Date: _____

Does your child have access to Insurance Benefits from their current employer? □ ***Yes*** □ ***No***

(Child 2) Last Name: (if different) _____ First Name: _____ Date of Birth: _____

Street Address: (if different) _____ City _____ State_____ Zip_____

Employer Name: _____ Hire Date: _____

Does your child have access to Insurance Benefits from their current employer? □ ***Yes*** □ ***No***

(Child 3) Last Name: (if different) _____ First Name: _____ Date of Birth: _____

Street Address: (if different) _____ City _____ State_____ Zip_____

Employer Name: _____ Hire Date: _____

Does your child have access to Insurance Benefits from their current employer? □ ***Yes*** □ ***No***

By signing this form you are acknowledging the above information is accurate to the best of your knowledge. You further acknowledge that you understand by providing inaccurate information that knowingly providing inaccurate information that action will be considered fraud and/or an intentional misrepresentation resulting in the following possible actions: health coverage may be terminated or rescinded, employment may be terminated or other disciplinary action may take place, and /or legal action may be initiated.

Print Name _____ ***Signature*** _____ ***Date*** _____