MONTANA UNIVERSITY SYSTEM
Office of the Commissioner of Higher Education

46 North Last Chance Gulch ◊ PO Box 203201 ◊ Helena, Montana 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

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:

1. Is at least 18 years of age.
2. Neither of us is married to another person.
3. Does not meet the legal definition of spouse or the MUS benefits plan definition of dependent child.
4. Is not related to the other as a parent, child, brother, sister half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild.
5. We have shared a primary place of residence for the last six consecutive months.
6. We are and will continue to be jointly responsible for our own welfare as evidenced by two of the following conditions:
    a. We have joint ownership or lease of a residence
    b. We have at least two of the following:
        i. Joint bank account
        ii. Joint billing statements (residential utilities or phone)
        iii. Joint credit card accounts
        iv. Joint loan agreements
        v. Joint car ownership
        vi. Other titles or deeds that are jointly owned
    c. We have designated each other primary beneficiaries in will, life insurance policies or retirement annuities.
    d. We have mutually-granted powers of attorney for health or otherwise.

Documentation for 6 above will be presented upon request. These documents will be returned to the applicant once a decision is made and will not be duplicated by the employer.

7. We acknowledge one or both of us have legal custody of the following listed children:

   1._____ 2._____ 3._____ 4._____

8. The Commissioner of Higher Education may waive the criteria set forth in 5) above if : (1) all of the other criteria have been met; and (2) upon showing of other clear and convincing evidence of an interdependent relationship between the employee and the adult dependent.

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 a 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 special enrollment event 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, Social Security Number 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.

_____
Signature of Notary Public

(Seal)

_____
Printed Name
Residing at _____
My Commission Expires:_____