

VERIFICATION OF ELIGIBILITY FOR DEPENDENTS

INSTRUCTIONS

This packet is to be used only if you do not have a copy of your latest Federal Tax Return listing the dependent/s you have or are enrolling in one or more of the following Banner Health Benefit Plans.

Please read and complete these forms completely as they will be used to verify your dependent/s under the Banner Health Medical, Pharmacy, Dental and/or Vision plans.

If the forms are not completed properly and returned within 7-10 days from the date on the enclosed Confirmation Statement, your dependents could be dropped from coverage.

<p>For <i>each</i> Dependent, please produce the attached form and the following documents:</p>	<ol style="list-style-type: none"> 1. A Completed and Signed VERIFICATION OF ELIGIBILITY FOR DEPENDENTS form (attached) <p><u>AND</u></p> <ol style="list-style-type: none"> 2. Spouse: Copy of marriage certificate plus proof marriage is still current (a household bill or statement of account listing your name and your spouse's name at the same address and dated within the past 60 days) <p><u>Domestic Partner:</u> Completed Domestic Partner packet to include the following:</p> <ol style="list-style-type: none"> A. Copies of driver's licenses, or state-issued identification cards, showing issues dates, dates of birth and correct current addresses <i>for both the employee and the domestic partner.</i> B. If the driver's licenses do not show that you have shared a common address for at least six months, additional documentation must be provided. <p>NOTE: The Domestic Partner may not otherwise be eligible for coverage under the Banner Health plans.</p> <p><u>Child/Children</u></p> <ol style="list-style-type: none"> a) Birth certificate; or b) Court order of adoption/legal guardianship/legal custody; or c) Birth card if the child's last name is the same as your last name or your spouse/domestic partner's last name; or d) Copy of divorce decree or other court order naming you, your spouse or your domestic partner as parent and including the child's name and date of birth.
<p>Send Documentation to The Service Center at Banner Plan Administration:</p>	<p>By secure FAX -- Use this page as Fax Cover Page</p> <p style="text-align: center;">FAX #: 480-684-6966</p> <p style="text-align: center;">RE: _____ (Employee Name)</p> <p style="text-align: center;">Total # of pages of fax: _____</p> <p><u>OR</u> By U.S. Mail: Banner Plan Administration P.O. Box 16423 Mesa, AZ 85211</p>



VERIFICATION OF YOUR ENROLLED DEPENDENTS

Your Name: _____ Employee ID: _____		PLEASE COMPLETE THIS SECTION	
List Dependent Name	Date of Birth	Circle correct eligibility definition for each dependent (See reverse side)	Verification of Dependency
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> First and Last Name <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Social Security Number		Spouse/DP	<input type="checkbox"/> YES - My Spouse meets the eligibility criteria listed on the back side of this form and I am including the appropriate documentation required for their continued participation
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> First and Last Name <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Social Security Number		Child Incapacitated Child	<input type="checkbox"/> YES - My Child meets the eligibility criteria listed on the back side of this form and I am including the appropriate documentation required for their continued participation
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> First and Last Name <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Social Security Number		Child Incapacitated Child	<input type="checkbox"/> YES - My Child meets the eligibility criteria listed on the back side of this form and I am including the appropriate documentation required for their continued participation
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> First and Last Name <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Social Security Number		Child Incapacitated Child	<input type="checkbox"/> YES - My Dependent meets the eligibility criteria listed on the back side of this form and I am including the appropriate documentation required for their continued participation

Please see reverse side for eligibility definitions and a list of the required documents for each.

Your signature confirms that, as of the date of listed below: (1) the persons you have identified above are eligible based on the definitions shown on the back of this page and (2) the documentation you have provided is authentic.

If you have questions, please call the Service Center at Banner Plan Administration, Monday through Friday, between 7:00 a.m. and 6:00 p.m., Mountain Standard Time.

Please allow 2 business days for processing if you fax your form (5 business days if you send it via US mail).

Signature Date Daytime Contact Phone Number

If there are any questions regarding this form, how would you prefer we contact you:

Email: _____@bannerhealth.com

The number listed above as daytime contact phone number.

Eligibility Documentation and Worksheet

A. SPOUSE or DOMESTIC PARTNER

Legally Married or Common Law Spouse (applies to Colorado residents only)

[opposite sex only]

Domestic Partner (same or opposite sex)

REQUIRED DOCUMENTS

For Spouse:

Copy of marriage certificate **plus** proof marriage is still current (a household bill or statement of account listing your name and your spouse's name at the same address and dated within the past 60 days)

For Domestic Partner:

Completed Domestic Partner packet to include the following:

A. Copies of driver's licenses, or state-issued identification cards, showing issues dates, dates of birth and correct current addresses *for both the employee and the domestic partner.*

B. If the driver's licenses do not show that you have shared a common address for at least six months, additional documentation must be provided.

NOTE: The Domestic Partner may not otherwise be eligible for coverage under the Banner Health plans.

B. CHILD - Step 1

* For eligibility purposes, "child(ren)" includes:

- natural, adopted, stepchild(ren), and child(ren) of your domestic partner
- child(ren) for whom legal custody or guardianship has been granted
- child(ren) under a Qualified Medical Child Support Order

Does your child meet one of these criteria for dependent eligibility?

- Unmarried child, stepchild, or adopted child who is less than age 25, **or**
- Unmarried child who is less than age 25 for whom you or your spouse has legal custody or guardianship, **or**
- Incapacitated child who is at least age 25, unmarried, and incapable of self-support due to a continuously disabling mental or physical handicap.

If your child/children meet one of these criteria they qualify as an eligible dependent. However, they must also qualify as a tax dependent. See Step 2

B. CHILD - Step 2

If your child meets any of the criteria in Step 1 above, they must **also** qualify as your tax dependent.

If you can check all the boxes in one (1) of the three categories in this section, then your child meets the definition of that Category and qualifies as your tax dependent and for coverage under the Banner Health Plans.

Qualifying Child Requirements

- Does the child live with you for more than ½ of the year?
- Is the child either (1) under 19, OR (2) under 24 and a full-time student, OR (3) age 25 or older and totally and permanently disabled?
- The child does not provide more than 50% of his or her own support for the year.

OR

Qualifying Relative Requirements

- I provide more than ½ of the child's support during the year?
- The child is not claimed as a tax dependent by any other person. If the child files his/her own taxes with a "single" status, he/she does not claim the exemption for himself/herself.

OR

Special Rule for Children of Divorced or Separated Parents

- The child is under the age of 19.
- The child received over half of his or her support for the year from one or both of the parents.
- The child was in the custody of one or both of the parents for more than half of the year.
- The child is a qualifying child or qualifying relative of one of the child's parents.