# Peralta Community College District Benefits Enrollment Checklist

(Special Note to Adjuncts: Include documentation of all full time equivalent (FTE) for Academic Term)

*(Shaded portion of the form does not apply to Adjunct Employees)*

Rev. 07/29/10

*You may download forms from our Benefits Information Center website (link provided below) or contact the Benefits Office for hard copies.*

| Information Received | Website Links |
|---|---|
| 1. Adjunct Benefit Open Enrollment Announcement | www.peralta.pswbenefits.net |
| 2. Initial / General COBRA | |
| 3. Kaiser Packet | |
| 4. Kaiser Disclosure & Plan Highlights | |
| 5. CoreSource Summary Plan Description | |
| 6. CoreSource Pre-Existing Application & Notice | |
| 7. CoreSource Caremark—List of Pharmacies | |
| 8. CoreSource Caremark—Mail Order Prescriptions | |
| 9. Spectera Vision Care Benefits | |
| 10. Delta Dental Overview | |
| 11. Delta Dental Evidence of Coverage | |
| 12. UnitedHealthCare Dental Lists / Costs | |
| 13. Flexible Benefits Plan Medical & Dependent Care Program | |
| 14. Section 132 Pre-Tax Parking & Commuter | |
| 15. Voluntary & Prepaid Legal Plan Overview & Service List | |
| 16. Tax-Deferred 403(b) & 457 Highlights & Comparison | www.peralta.edu |
| 17. Life Insurance Overview | www.peralta.pswbenefits.net |
| 18. Employee Assistance Program Overview | |
| 19. Life Insurance Certificate of Coverage | |
| 20. Long Term Disability Overview | |
| 21. Long Term Disability Certificate of Coverage | |
| 22. Voluntary Term Life CIGNA Overview | |
| **The following forms MUST be returned within 31 days from date of hire or state date (whichever occurs later )** *Received by Benefits Office or N/A* | |
| 23. Universal Enrollment Form | www.peralta.pswbenefits.net |
| 24. Pre-Existing Exclusion Application (except for dental) | |
| 25. Flexible Benefits Plan Enrollment Medical & Dental | |
| 26. CIGNA Voluntary Life Insurance Application | www.peralta.pswbenefits.net |
| 27. Cash in Lieu of Benefits Form | www.peralta.pswbenefits.net |
| **The following forms may be returned at any time:** | |
| 28. Pre-Tax Commuting Enrollment | www.peralta.pswbenefits.net |
| 29. Pre-Paid Legal Enrollment Form | |
| 30. Salary Reduction Agreement Form 403(b) & 457 | www.peralta.edu |

**WAIVER AND ACKNOWLEDGEMENT:** I have read & understand my options. If I enroll in a group insurance plan, I agree to notify the District within 30 days of a qualifying event. If I do not enroll now, I understand that I may enroll at a later date subject to open enrollment provisions. If payroll deductions are required for medical or dental, I agree that they will be pre-tax and I will advise PCCD if I prefer after tax deductions.

Signature: ______________________________ Date: ______________

# UNIVERSAL BENEFIT RE-ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM WILL BE EFFECTIVE 09/01/10 - 02/28/11

***ADJUNCT EMPLOYEES ONLY***

COMPLETE SECTIONS 1-8 AND RETURN TO THE BENEFITS OFFICE

*(Allow 10 days for processing adds and drops)*

NO LATER THAN FRIDAY, SEPTEMBER 17, 2010


PERALTA COMMUNITY COLLEGE DISTRICT

333 East 8th Street
Oakland, CA 94606


## 1. EMPLOYEE INFORMATION (please print)

| Employee Name (last name, first name, middle initial) | SHADED AREA FOR OFFICE USE ONLY: | |
|---|---|---|
| | EFFECTIVE DATE: | September 1, 2010 |
| Employee Address (street, city, state, zip code) | MEDICAL GROUP/DIVISION #: | Kaiser: 65-51 or<br>Coresource: Group 2 Division 49 |
| | DENTAL GROUP/DIVISION #: | Delta: 938-1501 or<br>UHC DMO: 729309 |
| | FORM REVIEWED & APPROVED: | |
| | DATE REVIEWED & APPROVED: | |

| | | |
|---|---|---|
| Home Phone: | Alternate Phone: | Email Address: |
| Work Location: | Occupation: **Adjunct Prof.** | Social Security Number |
| Date of Birth: | Date of Hire: | Date of Retirement: |
| Hours/Week: | Gender | Marital Status<br>☐Single ☐Married ☐Divorced ☐Separated ☐Widow<br>☐Domestic Partner |

## 2. INDIVIDUALS COVERED

| (A)dd<br>(C)hange<br>(D)rop | Last Name, First Name | Social Security Number | Date of Birth | Sex | Relationship<br>Spouse<br>Domestic Partner<br>Child - natural<br>Child - foster<br>Child - adopted | Totally Disabled? | State Type of Document Attached:<br>•Copy of most recent tax return<br>•Proof of relationship<br>•Proof of join ownership<br>•Other | Medical | Dental |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ☐Y ☐N | | | |
| | | | | | | ☐Y ☐N | | | |
| | | | | | | ☐Y ☐N | | | |
| | | | | | | ☐Y ☐N | | | |

If dropping dependents, please specify reason: ______________________________

## 3. BENEFIT PLANS

| | | | | |
|---|---|---|---|---|
| • MEDICAL/ VISION | *Choose one:* | ☐ Kaiser Permanente HMO<br>☐ Coresource PPO/Vision*<br>*Pre-existing condition limitations apply; 6 months for new hires; 18 months for late entrants<br>Division Name: Adjunct<br>Group #: 2 / Division #: 49<br>*Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs.* | *Choose one:* | (1)Employee Only<br>☐Kaiser<br>☐Coresource<br>(2)Employee + 1 dependent<br>☐Kaiser<br>☐Coresource<br>(3)Employee + family<br>☐Kaiser<br>☐Coresource |
| • DENTAL | *Choose one:* | ☐ Delta PPO Dental<br>☐ UHC DMO Dental *(MUST designate DMO provider)*<br>Name of DMO Provider:______________________<br>DMO Provider #:______________________<br>(You may obtain the DMO provider # by calling Customer Service at 800-999-3367)<br>*Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs.* | ***Choose one:*** | (1)Employee Only<br>☐Delta Dental<br>☐UHC Dental<br>(2)Employee + 1 dependent<br>☐Delta Dental<br>☐UHC Dental<br>(3)Employee + family<br>☐Delta Dental<br>☐UHC Dental |

Unless you check below, your premium WILL be deducted on a pre-tax basis from your PCCD pay:

☐ I do NOT wish to have my premiums deducted on a pre-tax basis.

Signature______________________________ Date______________________________

Print First Name______________________________ Print Last Name______________________________

Ed. 7/29/10

***Please attach Instructor Term Workload printout from *PROMT****

## 4. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? ☐Yes ☐No If yes, Medicare #________________
   If yes, who?________________
2. Is anyone listed eligible for Medicaid or CHIP? ☐Yes ☐No ID#________________
   If yes, who?________________
3. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months? ¨Yes ¨No If yes, complete the section below. Please list all current or prior medical coverage. Failure to provide complete information may result in significant delay of claims processing (attach additional sheets if necessary).

| COVERED PERSON'S NAME (last, first, M.I.) | Policy Holder's Name | Insurance Company Name | Type of Coverage | Policy # | Termination Date (if applicable) |
|---|---|---|---|---|---|
| | | | ☐Health<br>☐Other:________ | | |
| | | | ☐Health<br>☐Other:________ | | |
| | | | ☐Health<br>☐Other:________ | | |
| | | | ☐Health<br>☐Other:________ | | |

## 5. KAISER ENROLLEES MUST READ AND SIGN:

Kaiser Foundation Health Plan Arbitration Agreement:

☐Check if NOT enrolling in Kaiser

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

________________________________ ________________________________

EMPLOYEE SIGNATURE DATE

## 6. CORESOURCE ENROLLEES MUST READ AND SIGN:

☐Check if NOT enrolling in Coresource

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and CoreSource for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and CoreSource are giving up the right to have any dispute decided in a court of law before a jury. CoreSource and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

________________________________ ________________________________

EMPLOYEE SIGNATURE DATE

## 7. COMPLETE THE APPLICABLE SECTION BELOW TO DETERMINE YOUR TOTAL PER PAY PERIOD DEDUCTION:

### 50/50 Plan - see below for premium rates 09/01/10-02/28/11:

Medical Premium $__________ ÷ 2 = $__________ X 6 = $__________ ÷ 3 = $__________(your monthly share)
\+ Dental Premium $__________ X 6 = $__________ ÷ 3 = $__________ (your monthly share)

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: $__________________ (your monthly share)

### 100% Plan - see below for premium rates 09/01/10-02/28/11:

Medical Premium $__________ X 6 = $__________ ÷ 3 = $__________ (your monthly share)
\+ Dental Premium $__________ X 6 = $__________ ÷ 3 = $__________ (your monthly share)

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: $__________________ (your monthly share)

## PREMIUM RATES

Current 09/01/10 Monthly Premium Rates

| Medical PPO (Coresource) | |
|---|---|
| Single: | $ 666.42 |
| Two Party: | $1,488.96 |
| Three Party: | $2,236.90 |

| Medical HMO (Kaiser) | |
|---|---|
| Single: | $ 560.93 |
| Two Party: | $1,121.86 |
| Three Party: | $1,587.43 |

| Dental PPO (Delta) | |
|---|---|
| Single: | $ 66.45 |
| Two Party: | $ 112.97 |
| Three Party: | $ 172.78 |

| Dental DMO (UnitedHealthcare) | |
|---|---|
| Single: | $ 26.29 |
| Two Party: | $ 42.06 |
| Three Party: | $ 64.09 |

## 8. TERMS AND AGREEMENT (ALL EMPLOYEES MUST SIGN AND DATE BELOW):

In exchange for my enrollment, I agree to notify the District in writing within 30 days of the following:

1. my address change
2. change to my marital status resulting in adding or deleting a spouse or domestic partner
3. change to my eligible dependents status adding a newborn

I also acknowledge that in accordance with Peralta Community College District Board Policy, civil action may be brought against employees who make false statements or fail to notify the District of change in dependent status.

I agree to pay premium directly from my Peralta Community College District pay. If there are insufficient earnings, I will pay for benefits by personal check within the first 10 days of the coverage month or face cancellation of coverage for non-payment of premium. I understand that I am subject to post-enrollment premium payment audits and may owe for unpaid premiums at the end of the semester.

I understand that re-enrollment for future semesters is not automatic and that I need to resubmit each semester for which I am eligible.

______________________________ EMPLOYEE SIGNATURE

______________________________ DATE

Peralta Community College
Eligibility Affidavit
50% / 50% and 100% Plan
Fall 2010

RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN FRIDAY, SEPTEMBER 17, 2010. INCOMPLETE OR FORMS RECEIVED AFTER THIS DATE WILL NOT BE PROCESSED AND WILL BE RETURNED TO YOU.

## Section A: Personal Information

Employee's Name (Last, First, Middle Initial) - please print | Social Security Number | Date of Birth

Street Address - please print | City | State | Zip Code

Telephone Number (home) | Telephone Number (work) | Email Address

❑ *Check here if the above reflects any new / updated contact information.*

## Section B: Affidavit of Eligibility

Please answer Yes or No to questions 1, 2, and 3. Initial next to your response.

1. Are you currently employed by PCCD as any hourly faculty member? ❑ Yes ❑ No ________ (your initials here)
2. Do you have a fall assignment of 40% or greater? ❑ Yes ❑ No ________ (your initials here)
   (refer to the Instructor Assignment Roster—attach the Term Workload to this form)
3. Do you have other access to group medical insurance where all or part of the premium is paid through some source other than personal funds or a Community College District? ❑ Yes ❑ No ________ (your initials here)

## Section C: Benefit Options—Circle your Choices and Attach an Adjunct Universal Enrollment Form

| Coverage 50% / 50% Plan | Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments<br>Kaiser<br>Monthly Rate/Payroll Rate | Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments<br>CoreSource<br>Monthly Rate/Payroll Rate | Coverage 100% Plan | Your 100% Monthly Share: 6 months of coverage paid in 3 installments<br>Kaiser<br>Monthly Rate/Payroll Rate | Your 100% Monthly Share: 6 months of coverage paid in 3 installments<br>CoreSource<br>Monthly Rate/Payroll Rate |
|---|---|---|---|---|---|
| Single | $280.47/mo; $560.93/pr | $333.21/mo; $666.42/pr | Single | $560.93/mo; $1121.86/pr | $666.42/mo; $1332.84/pr |
| Two Party | $560.93/mo; $1121.86/pr | $744.48/mo; $1488.96/pr | Two Party | $1121.86/mo; $2243.72/pr | $1488.96/mo; $2977.92/pr |
| Three Party | $793.72/mo; $1587.43/pr | $1118.45/mo; $2236.90/pr | Three Party | $1587.43/mo; $3174.86/pr | $2236.90/mo; $4473.80/pr |

| Coverage<br>Employee makes 3 installments for 6 months of coverage | Delta Dental PPO Dental Plan<br>You pay full monthly premium | United HealthCare DMO Dental Plan<br>You pay full monthly premium |
|---|---|---|
| Single | $66.45 | $26.29 |
| Two Party | $112.97 | $42.06 |
| Three Party | $172.78 | $64.09 |

I understand that if I waive coverage or do not enroll in coverage, I can enroll at a later date if there is a QUALIFYING EVENT as permitted and defined by HIPAA governances.

## Section D: Payroll Deduction Authorization

50% / 50% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the above-referenced CIRCLED amounts from my monthly paycheck to pay for 50% of the medical premium cost and 100% of the dental premiums for the amount of coverage I have selected. Deductions will occur for the 3 pay periods **October, November, December 2010.**

________________________________________________ (please sign and date)

OR

100% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the above-referenced CIRCLED amounts from my monthly paycheck to pay for 100% of the medical and or dental premium cost for the amount of coverage I have selected. Deductions will occur for the 3 pay periods **October, November, December 2010.** I do not qualify for the District contribution and agree to pay 100% of the above-referenced circled premium. ______________________________________________________ (please sign and date)

## Section E: Complete and Attach Required Forms:

Term Workload Assignment , Adjunct Faculty Benefit Checklist & Universal Enrollment Form Checklist are attached to this Affidavit. _____
(initial here)

## Application of Pre-Existing Condition Exclusion

## Submit this form with the Adjunct Universal Enrollment Form

August 1, 2010

If enrolling on the Kaiser plan, complete sections A & C.
If enrolling on the CoreSource plan, complete sections A through C.

### SECTION A

Employee and/or Dependent Name(s): ______________________________________________

❑ ADJUNCTS ONLY: check here if enrolling in dental coverage.
❑ ADJUNCTS ONLY: check here if enrollment is continuing from Spring 2010 semester.

Hire date: ______________________

First eligible to enroll date: ____________

Definition of Pre-Existing Condition: medical advice, diagnosis, care, or treatment recommended or received within a **6 month period**. Generally, this **6 month period** ends on the day before the waiting period begins.

### SECTION B

As required under Federal law, we advised you and your eligible dependent(s) of contractual pre-existing condition exclusions under the self-funded plan (currently administered by CoreSource) offered by Peralta Community College District. Submit any evidence of prior coverage along with your Universal Enrollment form and within 30 days of coverage effective date. PCCD will only accept the ***Certificate of Creditable Coverage*** as issued from your prior insurer. Ask your former group insurance administrator for this ***Certificate***. Your prior insurer is required to provide it upon request. PCCD will assist you acquiring this document from the prior carrier or employer should you so request, in writing.

Your pre-existing condition exclusion period may be reduced by prior creditable coverage as defined by the law. As of this date, you have:

❑ Submitted the Certificate of creditable coverage and have satisfied the pre-existing conditions limitation period in full. Evidence is attached.

❑ Not submitted any evidence of prior creditable coverage. Therefore, the full limitation period applies.
❑ 6 months (timely enrollee) ❑ 18 months (late enrollee)

❑ Submitted certification of prior creditable coverage. This totals ________ days/months for all persons to whom this notice applies. This time can be used to offset the pre-existing condition exclusion period of our plan. Therefore, you will only be subject to __________ days/months of limitation for pre-existing conditions from your date of hire (this includes any applicable waiting period).

You have the legal right to submit further certification of prior waiting periods and creditable coverage as it becomes available. If you disagree with the findings of this notice, please submit your disagreement, in writing to: Jennifer Seibert, District Benefits Coordinator, Peralta Community College District, 333 East 8th Street,, Oakland, CA 94606, Phone number: 510 587-7868, Email: jseibert@peralta.edu

Note: *Should your claims be denied in whole or in part by the insurance company based on the application of a pre-existing conditions limitation in excess of that stated above, contact Benefits Office for assistance in resubmitting your claim.*

### SECTION C

I understand that if I am enrolling in the self-funded plan and I have been asked to provide a certificate of creditable coverage; if I am enrolling in the Kaiser plan, there is no pre-existing condition exclusion limitation for new or continuing enrollments on the plan.

______________________________ ____________________
Employee Signature Date

______________________________ ____________________
Employer Signature Date

## Peralta Community College District
## Required Documentation Matrix

The below matrix outlines the documentation options that you can submit to verify eligibility for each dependent enrolled with health coverage. Please note the following:

- Send photocopies only. **Do not send original documents.**
- Mark out any personal financial information such as income, account balances, payment amounts, and so on.
- Write the Employee's Name and Audit ID Number (located on cover letter) on each document.
- Retain a copy of all documentation and completed forms for your records.

# Spouse

Please provide the following document to verify Proof of Relationship and Joint Ownership.

- **First Page of Employee's or Spouse's Federal Tax Return**
  Photocopy of the first page of the employee or spouse's 2008 or 2009 tax return showing "Married Filing Jointly" *or* "Married Filing Separately." The spouse's name must be entered on the employee's tax form in the space provided after the "Married Filing Separately" status. *Note: This document satisfies both Proof of Relationship and Proof of Joint Ownership. Please mark out all financial information.*

  If you are unable to provide Employee or Spouse's Federal Tax Return, please provide one document from each of the following columns to verify Proof of Relationship and Proof of Joint Ownership

# Spouse or Domestic Partner

**If unable to provide a Federal Tax Return, please provide one document from each column to verify Proof or Relationship and Proof of Joint Ownership.**

| Proof of Relationship Documents | Proof of Joint Ownership Documents |
|---|---|
| • **Certified Marriage Certificate or License**<br>Photocopy of certified marriage certificate with appropriate signature and stamp/seal showing on photocopy or legally valid marriage license from appropriate state or local government. | • **Home Ownership**<br>Photocopy of mortgage statement dated within the past 3 months showing both names as mortgage holders/tenants. *Note: Please mark out all financial information.* |
| • **Immigration Paperwork**<br>Photocopy of immigration papers with appropriate signature and stamp/seal showing on photocopy that identifies employee/spouse relationship. | • **Joint Rental Property**<br>Photocopy of lease or rental agreement dated within the past 12 months showing both names as tenants. *Note: Please mark out all financial information.* |
| • **Notarized Affidavit of Common Law Marriage**<br>In cases of state recognized common law marriage, a Notarized Affidavit of Common Law Marriage.<br><br>• **Notarized Affidavit of Domestic Partnership**<br>Notarized Affidavit of Domestic Partnership. | • **Home/Rental Insurance**<br>Photocopy of homeowner's insurance, renter's insurance, or property tax receipt dated within the past 12 months showing both names as mortgage holders/tenants. *Note: Please mark out all financial information.*<br><br>• **Bank Statement**<br>Photocopy of joint bank account statement dated within the past 3 months showing both names as account holders. *Note: Please mark out all financial information.* |

| Spouse or Domestic Partner – continued | |
|---|---|
| **Proof of Relationship Documents** | **Proof of Joint Ownership Documents** |
| • **Registration of Domestic Partnership**<br>Photocopy of certificate of registration as the employee's domestic partner, if living in a city, county, state, or municipality providing for registration as domestic partner. | • **Credit Card Statement**<br>Photocopy of credit card statement dated within the past 3 months showing both names as card holders. *Note: Please mark out all financial information.* |
| | • **Automobile Statement**<br>Photocopy of automobile title or registration dated within the past 12 months listing both names as co-owners. |
| | • **Loan Statement**<br>Photocopy of a loan agreement dated within the past 12 months showing both names as co-borrowers. *Note: Please mark out all financial information* |
| | • **Miscellaneous Bills**<br>Photocopy of two different types of current bills dated within the past 3 months showing one of the spouse's names on each bill and the same common mailing address, e.g. telephone bill, electric bill, cable bill. *Note: Please mark out all financial information.* |
| | • **Beneficiary Statement**<br>Photocopy of designation as the primary beneficiary for life insurance or retirement benefits. *Note: Please mark out all financial information.* |
| | • **Driver's License**<br>Photocopy of the employee's and spouse's driver's licenses listing a common address. |

## Natural Child, Adopted Child, Step Child, Child of Domestic Partner, Dependent Child by Custody, Court Order, or Guardianship

Please provide **one** document for each child to verify Proof of Relationship and Residency.

- **Federal Tax Return**
  Photocopy of the first page of the employee's, spouses, or domestic partner's 2008 Federal Tax return showing the child listed as an eligible dependent. *Note: This document satisfies both Proof of Relationship and Proof of Principal Support. Please mark out all financial information*

- **Court Certified Divorce Decree**
  Photocopy of certified Divorce Decree with appropriate signature and stamp/seal showing on photocopy that documents required child health coverage. *Note: This document satisfies both Proof of Relationship and Proof of Principal Support.*

- **Certified Legal Guardianship**
  Photocopy of certified court ordered legal guardianship document with appropriate signature and stamp/seal showing on photocopy that documents required child health coverage. *Note: This document satisfies both Proof of Relationship and Proof of Principal Support.*

- **Ordered Health Coverage**
  Photocopy of Qualified Medical Child Support Order (QMCSO). *Note: This document satisfies both Proof of Relationship and Proof of Principal Support.*

- **Court Ordered Health Coverage**
  Photocopy of National Medical Support Notice (NMSN). *Note: This document satisfies both Proof of Relationship and Proof of Principal Support*

- **Court Ordered Health Coverage**
  Photocopy of court document with appropriate signature ordering child health coverage. *Note: This document satisfies both Proof of Relationship and Proof of Principal Support.*

**If you are unable to provide one of the above documents, please proceed to the next page.**

## Natural Child, Adopted Child, Step Child, Child of Domestic Partner, Dependent Child by Custody, Court Order, or Guardianship - continued

**If you are unable to provide one of the documents from the preceding page, you must provide one document from each of the following columns to verify eligibility for each dependent child.**

| Proof of Relationship Documents | Proof of Residency |
|---|---|
| • **Certified Birth Certificate** Photocopy of certified birth certificate with appropriate signature and stamp/seal showing on photocopy that identifies the parent/child relationship with the employee, spouse, or domestic partner<br>• **Hospital Verification of Birth (Less than 6 months old)** For children under 6 months old, photocopy of hospital verification of birth that identifies the employee, spouse, or domestic partner as the child's parent<br>• **Certified Adoption Certificate** Photocopy of certified court approved adoption document with appropriate signature and stamp/seal showing on photocopy that identifies the employee, spouse, or domestic partner as the child's parent<br>• **Adoption Agreement** Photocopy of placement letter/agreement from court or adoption agency that identifies the employee, spouse, or domestic partner as the child's parent<br>• **Report of Birth Abroad** Photocopy of report of birth abroad of a citizen of the United States (issued by the State Department with appropriate signature and stamp/seal showing on photocopy) that identifies the employee, spouse, or domestic partner parent/child relationship<br>• **Immigration Paperwork** Photocopy of immigration papers with appropriate signature and stamp/seal showing on the photocopy that identifies the parent/child relationship with the employee, spouse, or domestic partner | • **First Page of the Dependent Child's Federal Tax Return and First Page of the Employee's or Spouse's Federal Tax Return** Photocopy of the first page of the dependent child's 2008 or 2009 Federal Tax return **and** the first page of the employee's or spouse's 2008 or 2009 Federal Tax return showing a common address.<br>• **Driver's License** Photocopy of the employee's **and** dependent child's driver's licenses listing a common address.<br>• **Automobile Insurance Bill** Photocopy of the dependent child's automobile insurance bill showing the employee's address.<br>• **Dependent Child's Pay Stub** Photocopy of the dependent child's pay stub showing the employee's address.<br>• **School Record** Photocopy of school record of the dependent child showing the employee's address.<br>• **Physician Bill / Record** Photocopy of physician's bill or patient record of the dependent child showing the employee's address.<br>• **Day Care Bill or Contract** Photocopy of a Day Care Bill or Contract indicating the dependent child showing the employee's address. |

## Disabled Adult Child

For disabled dependent children, you must also provide one of the following:

- Photocopy of Social Security disability award letter
- Photocopy of current Social Security disability payment
- Photocopy of signed physician Health Care Statement for Disabled Dependents certifying that the dependent is incapable of self-sustaining employment and dependent upon the employee, spouse, or domestic partner due to a mental and/or physical disability. To request a blank Health Care Statement for Disabled Dependents, contact PSW Benefit Resources at 1-877-866-2623 or technicalservices@pswbenefits.com