IMPORTANT NOTICE TO EMPLOYEES COVERED ON THE CITY'S HEALTH INSURANCE PLANS

It is the policy of the City of Port St Lucie to verify eligibility of all dependents enrolled in the City's Health Insurance Plans. In order for the City to be able to continue to offer employees health insurance at the most affordable cost and with the highest level of benefits possible, the City feels it is necessary to ensure that all dependents enrolled in the City's Health Insurance are truly eligible to participate.

If you are enrolling dependents in the City's Health Insurance plan, you will be required to provide documentation verifying the eligibility of such dependents to Human Resources within 30 days of enrollment.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child (ren) of the participant or spouse. Dependent children may be covered through the end of the calendar year in which the child reaches age 26. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A foster child (up to age 18 years)
- A newborn (up to age 18 months) of a covered dependent (Florida)
- A child whom legal guardianship has been awarded to the participant or the participant's spouse

Over-Age Dependent Eligibility Age Requirements
Over-age dependent children are individuals who have reached the end of the calendar year in which they become 26, but have not reached the end of the calendar year they become 30 and meet the statutory requirements for enrollment. An over-age dependent must meet dependent eligibility requirements, including: • Unmarried with no dependents; AND • A Florida resident, or full-time or part-time student; AND • Not covered under any other health plan or policy, AND • Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Please know that the HR Staff will need to view the Original Document(s) and will make copies for our files. All documentation is required to be turned into Human Resources within 30 days of enrollment. **Failure to provide the required documentation by this date will result in retroactive termination of coverage for the dependent.** All documentation must be either the original document or a notarized/certified copy of original document.

Dependent Relationship	**Document(s) you will need to provide to verify eligibility**
Spouse	• Official Marriage Certificate **AND** • Certificate of Dependent Eligibility signed by employee
Child(ren) Under Age 26	• State issued birth certificate(s) **OR** legal guardianship court documents listing the employee or spouse as parent **AND** • Certificate of Dependent Eligibility signed by employee
Step-Child(ren) Under Age 26	• **AND** the appropriate dependent child documentation listed above
Child(ren) under Legal Guardianship or Custody Under Age 26	• **AND** court documents of the legal guardianship **OR** legal custody **OR** foster care.
Child(ren) under Foster Care Under Age 18	• **AND** court documents of foster care
Child(ren) adopted or in the process of adoption Under Age 26	• **AND** court documents of the legal adoption showing relationship to and placement in the employee's house **OR** adoption certificate issued through the courts
Grandchild(ren) OR other children not related	• **AND** State issued Birth Certificate of child(ren) stating child was born to an insured dependent child of employee or spouse **OR** • Legal Guardianship/Custody/Foster Care Document from the courts
Child(ren) Age 26 - 30	• State issued birth certificate(s) **OR** legal guardianship court documents listing the employee or spouse as parent **AND** • Certificate of Dependent Eligibility signed by employee • **AND** Overage Dependent Affidavit signed by employee

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim, or an application containing any false, incomplete, or misleading information is guilty of a felony of a third degree.

Please understand that any misstatements regarding your dependent's eligibility may result in disciplinary action up to and including termination of employment.

WHERE CAN YOU OBTAIN COPIES?

Births/Marriages/Divorces in St Lucie County

Birth Certificate

St. Lucie Health Department
Online: www.stluciecountyhealth.com/services/vitals.asp
St Lucie Health Department
5150 NW Milner Drive
Port St. Lucie, FL 34983
Phone (772) 878-4932
Office hours: Monday – Friday, 8:00am – 4:00pm

Marriage License

Clerk of the Circuit Court St. Lucie County
www.stlucieclerk.com/marriage/marriage.htm
201 South Indian River Drive
Fort Pierce, FL 34950 (2nd Floor)
(772) 462-6999
Office hours: Monday – Friday, 8:00am – 5:00pm

Births/Marriages/Divorces in other counties or out of state

www.vitalrec.com

CERTIFICATE OF DEPENDENT ELIGIBILITY

Employee Name:	**Department:**

Please list the dependent(s) you have covered under the City of Port St. Lucie Health Insurance Plan below. Please refer to the attached Dependent definitions to determine whether the individual(s) below meet the eligibility criteria for the City of Port St. Lucie.

Covered Dependent Information			
Dependent Name	**Dependent Relationship**	**For HR use only**	
		Docs Reviewed	**HR Initials**
1.		☐ Yes	
2.		☐ Yes	
3.		☐ Yes	
4.		☐ Yes	
5.		☐ Yes	
6.		☐ Yes	

1. I have provided HR with the applicable required dependent document(s) described in the enclosed Dependent Definitions Summary within 30 days of enrollment. ☐ Yes ☐ No
   If no, please explain why: _____

   _____

   _____

2. **Please read, sign and date below to indicate your agreement:**

   I have read the enclosed Dependent Definitions Summary and by my signature below, I certify that the individual(s) listed above is an(are) eligible dependent(s) under the City of Port St. Lucie's Health Insurance Plan. I further agree to provide proof of eligibility. I understand that if I fail to provide acceptable proof of eligibility within 30 days of enrollment, the City of Port St. Lucie may retro-actively remove the individual(s) from coverage. Any misstatements regarding your dependent's eligibility may result in disciplinary action up to and including termination of employment.

   I agree to notify the City of Port St. Lucie within the plan's time requirements if the above-named dependent's eligibility status changes under the City of Port St. Lucie's Health Insurance Plan. I also agree to reimburse the City of Port St. Lucie for any penalties or losses that the City may incur if this Certificate is untrue or incorrect, or if I fail to provide the notice required above. For more information on the City's time requirements, please refer to the Benefits Highlights Booklet or contact Human Resources.

Employee Signature: _____ **Date:** _____

Printed Name: _____

PLEASE SUBMIT THIS FORM WITH YOUR PROOF OF ELIGIBLITY FOR ALL DEPENDENTS LISTED ABOVE TO HUMAN RESOURCES WITHIN 30 DAYS OF ENROLLMENT.

OVERAGE DEPENDENT AFFIDAVIT (Age 26 – 30)

Employee Name:	**Department:**

A state mandate requires the City to extend healthcare coverage to dependents between the ages of 26 – 30. This law allows employees to cover these "overage dependents" under the City's Health Insurance Plan provided the following eligibility rules are met:

- Unmarried with no dependents; AND
- A Florida resident, or full-time or part-time student; AND
- Not covered under any other health plan or policy, AND
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped

Change of Dependent Eligibility Status
Should the status of the overage dependent change, the employee is required to notify Human Resources within 30 days to remove the dependent from the City's Health Insurance Plan. An overage dependent becomes ineligible for the plan with one of the following events: (1) the overage dependent marries, (2) the overage dependent becomes a parent, (3) the out-of-state dependent no longer attends school, or (4) the overage dependent becomes eligible for a group health plan or Medicare.

Please complete the following:

Dependent Name:	**Dependent's Date of Birth:**
Is this dependent unmarried without dependents of their own?	☐ Yes ☐ No
Is this dependent a Florida State Resident OR a full or part-time student?	☐ Yes ☐ No
Is this dependent covered under any other health plan or policy?	☐ Yes ☐ No
Is this dependent entitled to coverage under Medicare?	☐ Yes ☐ No

By signing below I represent that the statements on this form are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage/membership, and disciplinary action up to and including termination of employment.

I also understand that if the status of medical coverage for my overage dependent changes, it is my responsibility to notify the City's Human Resources Office within 30 days of the change.

Employee Signature: _____ **Date:** _____

Printed Name: _____