State of Connecticut
Dependent Eligibility Verification
ATTESTATION

Instructions: Please complete this attestation form confirming you are legally entitled to provide healthcare benefits to the listed spouse and/or other dependent(s) who meet the eligibility requirements for the State of Connecticut Healthcare Benefits Plan as outlined on page 3 of this form.

I am using this form to attest: (check all that apply)

☐ I have already submitted eligibility documents to the following State Agency/HR/Payroll Office:

_____

☐ I am not able to produce eligibility verification documents for my spouse because:

_____

_____

☐ I am not able to produce eligibility verification documents for my dependent(s) because:

_____

_____

State Employee or Retiree:

Last Name:	First:	Middle Initial:	Last 4 Digits SSN#:	State Employee ID #:	
Address:		Unit/Floor/Apt.:	City:	State:	ZIP:
Email:			D.O.B.:	Telephone #:	

Spouse, if applicable: (address needed only if different from employee or retiree)

Last Name:	First:	Middle Initial:	Telephone #:		
Address:		Unit/Floor/Apt.:	City:	State:	ZIP:
Email:			D.O.B.:	Telephone #:	

Legal Dependent, if applicable: (address needed only if different from employee or retiree)

Last Name:	First:	Middle Initial:	Telephone #:		
Address:		Unit/Floor/Apt.	City:	State:	ZIP:
Email:			D.O.B.:	Telephone #:	

Please copy this page if needed for additional dependents.

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State Employee or Retiree Certification:

By signing this form, I confirm that I, _____, am a participant in the State of Connecticut Healthcare Benefit Plan ("Plan") and have reviewed the information provided to me regarding the eligibility for benefits of my spouse, child(ren) and other dependents under the Plan. I confirm that the individuals listed as my spouse and dependent(s) meet the Plan's eligibility requirements for coverage as of the date of my signature on this document. I further confirm that I will notify the Plan promptly of any event that affects the eligibility for coverage of any dependent.

I understand that knowingly making false statements will be considered an act, practice, or omission constituting fraud or an intentional misrepresentation of a material fact that may result in retroactive termination of coverage for myself and/or the ineligible spouse or dependent(s); employment actions up to and including termination; and/or liability for fraud. I further understand that the Plan may forward such information to law enforcement agencies for appropriate action.

Additionally, I understand that if my healthcare coverage is terminated due to a knowingly false statement, I may be liable for the full reimbursement costs of payments made for any medical, prescription drug, and/or dental claims paid by the Plan for any ineligible spouse and dependent(s).

Spouse, if applicable:

- The individual listed on this form is my sole legal spouse, and we are not divorced or legally separated.

I understand my responsibility to notify the State in writing within thirty (30) days of a divorce or legal separation from my spouse. _____ (Employee or Retiree to Initial)

Dependent(s), if applicable:

- The individual(s) listed on this form are my legal dependents. _____ (Employee or Retiree to Initial)

Signature of State Employee or Retiree: _____ **Date**: _____

If you have questions about using this attestation form, please call Part D Advisors at (833) 839-8800

PLEASE SUBMIT COMPLETED FORM (pages 1 and 2) TO The PDA Verification Team at: 17199 N. Laurel Park Drive, Suite 400 Livonia, MI 48152**. Alternately you can scan or take a picture and upload to the secure web portal at: https://rev.partdadvisors.com/SOC**

State of Connecticut
Eligibility Rules

State Medical and/or Dental Benefit Plan Dependent Eligibility Rules

Spouse or recognized civil union partner. The lawful spouse of the covered State employee or retiree under a legally valid existing marriage or the State employee or retiree's recognized civil union partner as defined by the State of Connecticut.
Except as set forth in this section, an individual from whom a State employee or retiree is divorced or legally separated is not eligible for coverage.

State employee or retiree

Exceptions:

» An individual from whom the State employee or retiree is legally separated may continue coverage under the Medical and/or Dental Benefit Plan for up to three years following the date of the judgment or until the remarriage of either party, whichever occurs first, provided the former spouse was covered by the Medical and/or Dental Benefit Plan immediately before the legal separation and the legal separation agreement requires the State employee or retiree to provide health insurance coverage for the legally separate spouse and pays 100% of the cost of individual coverage (employee plus State share) for the former spouse on a post-tax basis. This will be in addition to the State employee or retiree's cost of coverage; or

» An individual from whom the State employee or retiree is divorced may continue coverage under the Medical and/or Dental Benefit Plan for up to three years following the date of the judgment or until the remarriage of either party, whichever occurs first, provided the ex-spouse was covered by the Medical and/or Dental Benefit Plan immediately before the divorce and the judgment requires the State employee or retiree to provide health insurance coverage for the ex-spouse. The State employee or retiree pays 100% of the cost of individual coverage (employee plus State share) for the former spouse on a post-tax basis. This will be in addition to the cost of coverage for state employees or retirees.

• **Child of a state employee or retiree, or spouse of a state employee or retiree.** A child of a state employee or retiree, or a state employee's or a retiree's spouse, including a stepchild; a child legally placed for adoption; or a legally adopted child through the end of the calendar year in which they turn age 26.

• **Newborn child.** Coverage under the Medical Benefit Plan shall be provided for a newborn child of the State employee or retiree from birth. The State employee or retiree must submit a completed enrollment form to their employing agency within 91 days after the date of birth to maintain coverage for the newborn.

• **Newborn of a covered dependent child.** A newborn child of an enrolled female dependent child is eligible for coverage from birth up to and including 31 days immediately following birth. The newborn child of a covered dependent child is not eligible for coverage under the Medical Benefit Plan beyond the 31-day period.

• **Disabled child.** A disabled child who is incapable of sustaining employment by reason of physical or mental disability may continue coverage beyond the age limit set forth in the Medical Benefit Plan, provided he/she: - Is incapable of sustaining employment by reason of physical or mental disability as certified by a physician and for whom the State employee or retiree (or his/her spouse or civil union partner) is chiefly responsible for support and maintenance; and - Became disabled before the limiting age for a dependent child and had comparable coverage as a dependent at the time of enrollment; and - If over the age of 26, is unmarried. Proof of such disability and child's dependency upon the member must be received by the medical benefit carrier within 31 days of the date upon which the child's coverage would have terminated in the absence of such disability. The disability must be certified at that time or at enrollment by a physician. Proof of continued disability and continued dependency must be provided no more than annually thereafter.

State of Connecticut
Eligibility Rules

• **Minor child (ward) for whom a state employee or retiree is the legal guardian.** A minor child or ward who resides with a state employee or retiree and for whom the State employee or retiree (or his/her spouse or civil union partner) has been named the minor child's legal guardian by a court of competent jurisdiction may be enrolled as a dependent. Unless the minor child meets the exception in the following bullet point, coverage will end when the child or ward attains 18 years of age or upon the termination of guardianship, whichever first occurs.

• **Continuation of coverage for the former ward after the termination of legal guardianship.** When the covered person demonstrates that a former ward who was enrolled under the Medical and/or Dental Benefit Plan prior to reaching the age of 18 continues to be dependent upon him/her (either as a "qualifying child" or a "qualifying relative" for federal income tax purposes), coverage may be available beyond the legal guardianship age until the last day of the calendar year in which the child reaches age 26. Proof of continued dependency must be provided annually. When the covered person continues in a parental/supportive relationship with a former ward who was enrolled in the Medical and/or Dental Benefit Plan prior to reaching the age of 18 but is not eligible to claim the child as a dependent for federal income tax purposes, the fair market value of such coverage will be imputed as income to the covered person.

• **Qualified Medical Child Support Orders (QMCSO).** A dependent child may be covered under a domestic relations order issued by a state court to a parent who is a covered State employee, retiree, or their spouse, as long as the child is under 26. Enrollment may be required even when the child was not previously covered under the Medical and/or Dental Benefit Plan.