HC

For HRRIS BTT Use Only
Event Date ________________________
Input Elections ____________________

University of Michigan

Stepchild Dependency Agreement

For Stepchildren of an Active Faculty or Staff Member

Attach this completed and signed form to a completed Benefits Enrollment/Change form, available on the Benefits Office Web site at www.umich.edu/~benefits/forms/change.htm. Both forms must be received by the HRRIS Benefits Transaction Team **within 30 days** after the event. Please print all information in **black** ink.

1. U-M Faculty or Staff Member Information

Name (Last, First, Middle Initial)	UMID	U.S. Social Security Number (If UMID is Unknown)
Email Address	Daytime Phone Number	

2. Stepchild Information

I request that my stepchild ________________________________ , be added to my current coverage(s). I certify that this child **meets all of the eligibility requirements shown below**:

1. Is unmarried, and
2. Is under age 25, and
3. Is legally residing with me as a member of my household but may be temporarily away from home attending school, and
4. Qualifies for dependency tax status as a legal exemption under the Internal Revenue Code for federal income tax purposes and will be claimed as an exemption on my IRS return for the present tax year, and
5. Is not already covered through the University as a dependent on another University employee's coverage, and
6. Is not eligible for coverage as a University employee.

I request that my stepchild be added to my current coverage(s) effective _________________________ (date all of the above requirements were satisfied). My stepchild is now eligible for enrollment under my University coverage(s) because of the following change:

☐ My stepchild is now legally residing with me.

☐ My stepchild now qualifies as a legal tax exemption and will be claimed as an exemption on my IRS return for the present tax year.

☐ My marriage to ____ on _______________________ .
Name of Stepchild's Parent — Date of Marriage

☐ My stepchild was previously covered under another University employee's coverage.

Name of University employee: ______________________________ and lost coverage on: ____________________.

3. Certification and Signature

By my signature below, I understand, agree and/or confirm that:

1. Any dependents I am enrolling meet the eligibility requirements described above.
2. Upon request, I will furnish satisfactory evidence of such dependency upon request by the Benefits Office or the health insurance company.
3. By my signature on this application, I certify that I understand and agree that to claim coverage for an ineligible dependent is serious misconduct, and in the event of such misconduct, I agree to reimburse the University for any costs incurred, and may be subject to disciplinary action.
4. If there is any change in the status of my stepchild listed on this form, I will be responsible for notifying the University within 30 days of such change.
5. I affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences, including loss of benefits, discipline, or appropriate legal actions.
6. Further, I have read and understand the reverse side of this form and agree to the terms and conditions listed there.

_______________________________________ _______________________________________
Signature of Faculty or Staff Member — Date Signed

Stepchild Dependency Agreement

Terms and Conditions

By signing the front of this form you agree to abide by the following:

IRS Section 125 Restrictions
Dependents can only be added or deleted mid-year if a family status change occurs which is consistent with the benefits change that is being made. Notify the Benefits Office of the family status change by completing the required forms **within 30 days** of the event. If you fail to notify the Benefits Office within 30 days of the event, you must wait until the next Open Enrollment in which you are eligible to participate to make the change. Family status changes include marriage, divorce, the birth or adoption of a child, death of a dependent, or a change in employment status (for you, your spouse or other qualified adult), such as a leave of absence without salary, a job termination or new job commencement.

To Add a Dependent to Your Current Coverage

Your dependents must meet the eligibility rules listed below.

Marriage
To be covered, your new spouse must be added to your coverage within 30 days of your date of marriage. The effective date of coverage will be retroactive to the date of marriage. Attach a copy of the marriage certificate or a Declaration of Marriage to the Benefits Enrollment/Change form.

Other Qualified Adult
An other qualified adult (OQA) must be added to your coverage within 30 days of meeting all of the OQA eligibility criteria as specified on the Benefits Office Web site at: www.benefits.umich.edu/eligibility

The effective date of coverage will be retroactive to the date of eligibility. Attach a copy of the completed Certification of Eligibility for Other Qualified Adult form to the Benefits Enrollment/Change form.

Birth
Your new child must be added within 30 days of the date of birth. The effective date of coverage will be retroactive to the date of birth.

Adoption
Your adopted child must be added to your coverage within 30 days of the adoption or placement for adoption. Coverage will be effective the date of the adoption. The Benefits Office must verify the date of adoption by reviewing the adoption documentation. For U.S. adoptions, attach the court signed petition for adoption or adoption decree to the Benefits Enrollment/Change form. For international adoptions, attach a copy of the visa or passport page that identifies the date of U.S. entry and a copy of the adoption orders signed by a magistrate or other government official.

Legal Guardianship
When you accept legal guardianship of a child, the child should be added to your coverage within 30 days of the date the petition is signed by the court. A copy of the signed court order must be provided to the Benefits Office for review. Coverage becomes effective on the date the court order is effective, or on the date the child moves into your home, whichever is later.

Principally-Supported Children
If you provide principal support for a relative such as a grandchild or nephew, you may cover her or him through the end of the year in which the child turns age 19. The dependent must be related to you by blood or marriage. You must have supported the dependent for a minimum of six full months. Coverage becomes effective 90 days after the application is received by the Benefits Office, which means that the minimum waiting period is nine months. This waiting period does not apply to stepchildren. Attach a copy of the Application for Principally Supported Child and Employee Certification to the Benefits Enrollment/Change form.

Stepchildren
Your unmarried stepchildren, in the custody of and legally dependent on your spouse, who are members of your household, can be added to your coverage within 30 days of the date of marriage and covered through the end of the month in which they turn age 25. Coverage becomes effective on the date of your marriage.

Your stepchildren who did not satisfy the above eligibility requirements at the time of your marriage and later become eligible due to a change in residence or tax exemption status must be added to your coverage within 30 days of becoming newly eligible. Coverage becomes effective on the date eligibility requirements are met. Attach a copy of the Stepchild Dependency Agreement form to the Benefits Enrollment/Change form.

Children of an Other Qualified Adult
Unmarried children, in the custody or care of and legally dependent on your other qualified adult (OQA), who are members of your household, can be added within 30 days of the date the OQA meets all of the OQA eligibility requirements. Coverage becomes effective on the date all of the other qualified adult eligibility requirements are met and continues through the end of the month in which the dependent child turns age 25.

To Delete a Dependent from Your Current Coverage

Death of a Dependent
Provide the date of death of the dependent on a Benefits Enrollment/Change form.

Job Commencement, Job Change of Dependent with Benefit Eligibility, or Spouse's Open Enrollment
If your spouse, OQA, or dependent child becomes eligible for benefits through their employer or has Open Enrollment, you may remove them from your benefits. They must be removed within 30 days of the coverage effective date under the other plan. You may remove them only from those benefits in which they actually newly enroll (i.e., you may not remove your dependent from your dental coverage if the dependent newly enrolls in medical coverage only). Coverage will be cancelled the first of the month following the month in which they are newly eligible.

For all other dependent deletions, including divorce, ineligibility of a dependent or ineligibility of a dependent child, please use the "Notice of COBRA Qualifying Event" form available from the Benefits Office Web site at: www.umich.edu/~benefits/forms

Release of Information
The Benefits Office will not release any information about you except:
(1) when you request it in writing, or
(2) when the release is necessary to process or review a claim (for example, to another insurance company).

If requested to do so, the Benefits Office will notify you of the information released and to whom.

Important Notice
You cannot cover under your University of Michigan benefits plans:
(1) Anyone who works for the University and has his or her own coverage as an employee of the University;
(2) Any dependent child who works for the University and is eligible for benefits as an employee of the University.
(3) Any eligible dependents who are already covered by another employee of the University, unless you are court-ordered to provide such coverage;
(4) Anyone who is not your legal spouse or eligible dependent;
(5) Yourself if you are covered by another University of Michigan employee in the same plan.

When you sign this form, you confirm that you understand and agree that claiming such coverage is misconduct, and you agree to reimburse the University for any additional costs incurred as a result of that misconduct.

Authorization
You authorize any doctor, hospital or other provider rendering service to you or your dependents to furnish to the plan you have selected on this application any information requested concerning medical information, claims and other insurance payments.

Requested Documentation
The University reserves the right to require proof of dependency upon request. When you sign this form, you agree to provide such documentation upon request.

Questions?
If you have questions, view the Benefits Office Web site at www.umich.edu/~benefits, or call the HR/Payroll Service Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.).

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-763-0363.
Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **Campus Mail or U.S. Mail to:**
HRRIS Benefits Transaction Team
4005 Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1281

Drop It Off In Person

Bring a photocopy of your completed form and ask the receptionist to stamp your form "received" for your records.

U-M Ann Arbor
Benefits Office
Wolverine Tower – Low Rise G250
3003 South State Street
Ann Arbor, MI 48109-1278

U-M Flint
Office of Human Resources
213 University Pavilion
303 East Kearsley
Flint, MI 48502-1950