Washington University in St.Louis

SCHOOL OF MEDICINE STUDENT HEALTH SERVICES
DEPENDENT VERIFICATION AFFIDAVIT

Student ID	**Email Address**
Student Name: (LAST, MI, FIRST)	**Phone NO.**

Please review the instructions, the definition of Dependents Eligible for WUSM Student Health Service benefits. Complete the information below on those dependents that you wish to enroll for benefits. Failure to return this affidavit will result in ineligibility for or loss of health/dental coverage for your dependent(s).

Does your Spouse/Domestic Partner or Dependent Child(ren) reside less than full-time with you? ☐ yes ☐ no
Is your Spouse/Domestic Partner eligible for coverage through his/her school or employer? ☐ yes ☐ no
(If you answered yes to any of the above, Student Health Service benefits are not available for such dependent.)

Is your Dependent Child(ren) eligible for benefits as a dependent of someone other than you? ☐ yes ☐ no
Does your Dependent Child(ren) qualify for coverage through Medicaid and the Children's Health Insurance program?
☐ yes ☐ no

Proof of creditable coverage is required for dependents

Dependent Eligibility Verification				
Dependent Name/ Date of Birth	Gender	Relationship	Eligible for coverage?	If required, I can provide a copy of the legal documents to support this person's eligibility
	☐ Male ☐Female	☐Spouse ☐Domestic Partner	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No
	☐ Male ☐Female	☐Natural Child ☐Stepchild ☐Legally Adopted Child ☐ Legal Guardianship ☐Child of Domestic Partner	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No
	☐ Male ☐Female	☐Natural Child ☐Stepchild ☐Legally Adopted Child ☐ Legal Guardianship ☐Child of	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No

Student Health Service
660 S. Euclid • Box 8030 • St. Louis, MO 63110 • (314) 362-2346 • Fax (314) 362-0058

		Domestic Partner		
	☐ Male ☐Female	☐Natural Child ☐Stepchild ☐Legally Adopted Child ☐ Legal Guardianship ☐Child of Domestic Partner	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No
	☐ Male ☐Female	☐Natural Child ☐Stepchild ☐Legally Adopted Child ☐ Legal Guardianship ☐Child of Domestic Partner	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No
	☐ Male ☐Female	☐Natural Child ☐Stepchild ☐Legally Adopted Child ☐ Legal Guardianship ☐Child of Domestic Partner	☐ Yes ☐ No, Drop from coverage	☐ Yes ☐ No

By my signature on this affidavit, I certify and warrant to Washington University School of Medicine Student Health Service that all information on this dependent verification affidavit is true, correct and current as of the date signed. I agree to provide supporting documentation upon the request of Student Health Service. I understand if I knowingly submit false information, my coverage may be terminated and I may be subject to disciplinary action. Please remove any dependent(s) from the health plan that I have indicated above as not eligible for coverage**.**

_______________________________________ ____________________

Student Signature ***Date***

Complete and return this affidavit to Student Health Service
Campus Box 8030

Student Health Service
660 S. Euclid • Box 8030 • St. Louis, MO 63110 • (314) 362-2346 • Fax (314) 362-0058

DEPENDENT VERIFICATION AFFIDAVIT INSTRUCTIONS

Student Health Service performs an annual dependent eligibility review for its Plan. Please use this DEPENDENT VERIFICATION AFFIDAVIT to list the individuals you currently cover or wish to cover as dependents through Student Health Service. The definition of eligible dependents is provided below. Please list each dependent and check the appropriate box(es) for each dependent.

The affidavit must be signed and returned in order to have dependent coverage. It is important that your responses be accurate as any inconsistencies discovered will be investigated and may result in severe negative consequences. Student Health Services will terminate your dependent coverage if you do not respond and/or it is determined that your dependents are not eligible.

If you find that any or all of your covered dependents do not qualify as eligible dependents, you may take this opportunity to request that coverage be terminated. Student Health Service will not take any disciplinary action based on benefits received by, or information submitted concerning, those ineligible dependents if they are dropped as part of this dependent eligibility review.

Student Health Service will not assume any liability resulting from terminating coverage of the ineligible dependents. To terminate the coverage of an ineligible dependent, return the enclosed form with the ineligible dependent(s) noted by checking the "No, drop from coverage" box next to their name.

DEPENDENTS ELIGIBLE FOR COVERAGE UNDER THE PLAN ARE:

1. Your legal spouse or domestic partner. Your spouse/domestic partner must reside with you, not be eligible for coverage through his/her school or employer and be dependent on you for support and maintenance.
2. Your (or your spouse's/domestic partner's) children (including natural children, stepchildren, legally adopted children, children placed with you for adoption, or children for whom you are the legal guardian) from birth to 19 years of age if they are not eligible for coverage as a dependent of someone other than the student and do not qualify for coverage through Medicaid and the Children's Health Insurance program.

DOCUMENTS TO SUPPORT DEPENDENT ELIGIBILITY

Student Health is entitled to request and you may be required to provide a copy of one or more of the following documents to support your dependents' eligibility:

- marriage certificate or license
- domestic partner verification form
- proof of residence for domestic partner
- divorce decree
- birth certificate
- tax return
- final adoption certificate
- legal adoption agency or placement document
- legal document for court-appointed guardianship

Student Health Service
660 S. Euclid • Box 8030 • St. Louis, MO 63110 • (314) 362-2346 • Fax (314) 362-0058