



DECLARATION OF ADULT DEPENDENT

Health Care Trust

Employee Name _____

Employing County or Group _____

Please identify your eligible adult dependent below:

Name _____

Date of Birth _____

Social Security Number _____

Eligibility

I certify as an employee of the _____ (County or Entity) and an enrolled participant in the MACoHCT group medical benefit plan, that the above identified person meets the following criteria for an eligible adult dependent, and I have not claimed a spouse or another adult dependent. (Documentation of the criteria below must be made available for review upon request.)

The eligible adult dependent:

- _____ A. Is at least 18 years of age;
- _____ B. Has had joint ownership or joint tenancy of a residence with me for at least the most recent twelve (12) consecutive months, and the jointly-owned or jointly-leased residence has served as the primary place of residence for each of us during the same period;
- _____ C. Does not meet the MACoHCT eligibility requirements of a spouse or a dependent child;
- _____ D. Does not have a parental relationship with me;
- _____ E. Is not related to me by blood or marriage;
- _____ F. Has a financially-interdependent relationship with me as evidenced by at least three (3) of the following:
 - 1. Joint ownership or lease of a motor vehicle;
 - 2. At least one joint liability such as a loan or credit card;
 - 3. Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
 - 4. Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities.

CRITERIA CERTIFIED _____

Human Resource Officer

Notification of Change in or Termination of Adult Dependent Relationship

I agree that if the adult dependent relationship as designated above, no longer exists, I will notify my employer and Plan Administrator within 60 days of such change.

Certification

I understand all of the following:

1. The eligibility and coverage of an adult dependent will cease at the end of the month in which any of the above criteria (A through F) are no longer met;
2. Under federal and state law, benefit coverage of certain adult dependents described above may result in taxable income to the employee and may be subject to income tax withholding and applicable payroll taxes;
3. Coverage for an eligible adult dependent may only be activated during open enrollment or if an applicable qualifying event occurs during the plan year;
4. Montana Association of Counties Health Care Trust must be give written notice within thirty (30) days from the employer of any change in circumstances attested to in this document.
5. Falsely or fraudulently certifying eligibility for adult dependent coverage or failing to inform MACoHCT of a relevant change in eligibility requirements in any respect may result in immediate termination of coverage of the adult dependent and the employee and the adult dependent may be subject to criminal prosecution, fine or imprisonment as provided by law.
6. The employee will be liable for all expenditures for coverage and benefits obtained because of any misrepresentation or omission in certifying eligibility for benefit or in failing to inform MACoHCT of a change in eligible criteria.

I further understand and acknowledge that the Montana Association of Counties Health Care Trust reserves the right to require copies of any or all of the above-listed documents. If I fail to provide the copies when requested, I understand that medical benefit coverage for the named adult dependent will be immediately terminated.

I certify and affirm that the eligibility assertions made herein are true and correct to the best of my knowledge and that I understand my obligations as stated herein.

