The University of Vermont

Employee ID:_______________

Certification of Dependents

UVM employees may elect benefit coverage for their spouse, civil union partner or dependent children. In order to qualify, dependents must meet the eligibility conditions of The University medical, dental and life insurers. Dependents are considered qualified dependents if they are the spouse, civil union partner or dependent child of the employee.

Employee Information		
Last Name	First Name	MI

Certification of My Spouse/ Civil Union Partner Information

A spouse or civil union partner will qualify if:

1. The marriage or civil union is valid in the jurisdiction in which it was solemnized, and
2. The marriage or civil union does not violate Vermont law or the express public policy of the State of Vermont.

Last Name	First Name	MI
Street Address (if different than employee)	City, State	Zip code
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender (F/M)

Check here if the above dependent is a **UVM employee** ☐	Check here if the above dependent is a **Retiree** ☐

Check if you and your spouse are parties to a MARRIAGE OR CIVIL UNION is recognized by the State of Vermont and the federal government (if applicable).

☐ Marriage	☐ Civil Union	Date:

Certification of My Spouse or Civil Union Partner

I hereby certify that the person listed above is my spouse or party to a civil union and that they meet the eligibility requirements for spouse or party to a civil union. **Note**: The University reserves the right to request, at the employee's expense, an opinion from a qualified attorney attesting to the validity of the marriage or civil union according to the laws of the jurisdiction in which it was solemnized. The University further reserves the right to seek an independent verification of validity.

Signature:	Date:

The University of Vermont

Employee ID:_______________

Certification of My Dependent Child(ren):

In order for children to be covered as dependents under The University's health, dental and life insurers, the following conditions must be met:

1. For **medical, dental, and life** insurance benefits, the child(ren) must be under age 26
   - Or over **26**, and mentally or physically incapacitated. (You must have applied for incapacitated child status prior to the child's 26th birthday.)
2. The child must be the biological child, stepchild, foster child, ward or legally-adopted child of the employee* or their spouse/civil union partner, or the legal dependent of the employee* or their spouse/civil union partner.
   * or Post Doc Fellow/Trainee in the case of medical coverage

1	Last Name of Child		First Name of Child	
	Date of Birth (MM/DD/YYYY)	Gender (F/M)	Social Security Number	Relationship to Employee
2			First Name of Child	
	Date of Birth (MM/DD/YYYY)	Gender (F/M)	Social Security Number	Relationship to Employee
3	Last Name of Child		First Name of Child	
	Date of Birth (MM/DD/YYYY)	Gender (F/M)	Social Security Number	Relationship to Employee
4	Last Name of Child		First Name of Child	
	Date of Birth (MM/DD/YYYY)	Gender (F/M)	Social Security Number	Relationship to Employee

Certification of My Dependent Child(ren)

I hereby certify that the above child(ren) meet(s) all of the eligibility requirements set forth above.

Signature:	Date:

Signature required on EACH page

Employee ID:_______________

Acknowledgments

In completing and signing this certification form, I am aware of and agree to the following terms and conditions:

1. Penalty for False Certification

I understand that falsely certifying eligibility, or otherwise misstating, misrepresenting or omitting facts relevant to eligibility, may result in disciplinary action (including dismissal). I further understand that such conduct may subject me to civil and/or criminal prosecution for benefits wrongfully obtained and that I may become liable for such benefits and expenses associated with their recoupment (including reasonable attorney's fees).

2. Duty to Notify of Changes in Status

I agree to notify Human Resources at The University of Vermont **in writing within 20 days of any of the following changes**:

a) any change in the status of my marriage or civil union (marriage, divorce, death, etc.)

b) any change in the status of my dependent children, including:

- change in dependent relationship status
- eligibility for Social Security Disability Insurance (SSDI) Benefits

c) any birth or adoption in my family

d) the death of any benefit participant or beneficiary in my family

3. Tax Status of Health Care Premiums Paid by The University of Vermont on Behalf of a Civil Union Partner

I understand that the Internal Revenue Service regulations do not exempt benefit premiums paid by The University of Vermont on behalf of an Employee's civil union partner (or Post Doc Fellow's/Trainee's civil union partner). Therefore, for employees The University of Vermont will automatically include the value of its health care contribution or COBRA equivalent in my taxable income. Post Doc Fellows/Trainees will need to include this value in their taxable income. I further understand that if there is some circumstance for which The University of Vermont contribution to my civil union partner's health care premium might be excluded from my taxable income, I can bring this matter to the attention of Human Resources. The University of Vermont, in considering the taxability of the benefit premium, will require a written opinion from my qualified tax advisor. The University of Vermont, at its discretion, will seek legal advice on questionable opinions.

Vermont amended its personal income tax law effective January 1, 2001. This amendment allows The University of Vermont to exempt employer benefit premium payments made on behalf of civil union partners from Vermont income tax. Employer premium payments for civil union partners are, however, subject to all other applicable taxes.

4. Confidentiality

I understand that this application and the information contained in it will be maintained by The University of Vermont as a confidential personal document, and shall not be disclosed in the absence of the Employee/Post Doc Fellow/ Trainee's written consent except as necessary to provide benefits coverage or otherwise as required by law.

5. Affirmation

I affirm that the assertions in this certification form are true and accurate to the best of my knowledge and that The University of Vermont may at any time request verification of marriage, marital equivalency with a party to a civil union, or legal responsibility for a dependent child. This verification may include, but would not be limited to, the requirement that I provide a copy of my marriage or civil union certificate. In certifying the dependency of a child, a birth certificate or court-generated legal document may be required.

Signature: ____ Date:_________________

Signature required on EACH page