Dependent Eligibility Audit Verification Form

ARCHER & GREINER PC
ATTORNEYS AT LAW

Acknowledgement of Dependent Eligibility Rules

I _____ (insert name) understand that I may cover any or all of my eligible dependents under the **Archer & Greiner** benefits program according to the eligibility rules of the group health plan, and that eligible dependents in such plan[s] include:

- Your eligible spouse, only if they are not eligible to receive benefits through their employer
- Your dependent children who have not reached the age of 26 may also be eligible to receive benefits if coverage is elected. For purposes of benefits your dependent children include:
  - Natural children
  - Any legally adopted children
  - A stepchild, as long as you and the child's natural parent remain married
  - A child placed in your home while adoption procedures are underway
  - Children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible.
- Children for whom you are required to provide healthcare coverage pursuant to a Qualified Medical Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a settlement agreement) issued by a court or through an administrative process under state law, that creates or recognizes the existence of the right of a child to, or assigns to the child the right to receive benefits for which you are eligible under the Plan.
- Your disabled children. A disabled child is one who is incapable of self-sustaining employment because of mental or physical disability. Your child must be unmarried, primarily dependent upon you for support, and not eligible for any other type of health coverage (other than Medicaid or Medicare). The child's disability must have started before he or she became age 26 and the child must depend primarily on you for support. For a disabled child to remain covered beyond age 26, you must provide proof of the child's disability within 30 days of the date on which the child becomes age 26. Coverage will end on the last day of the benefit year in which the child ceases to qualify as a disabled child.

YOUR DEPENDENTS ARE NO LONGER ELIGIBLE FOR THE PLAN ONCE THEY CEASE TO MEET THE ELIGIBILITY CRITERIA AS DESCRIBED ABOVE AND YOU MUST INFORM (BENEFITS WITHIN (31) DAYS OF THE EVENT THAT CAUSED YOUR DEPENDENTS TO NO LONGER BE ELIGIBLE FOR THE PLAN.

Acceptance of Dependent Eligibility Rules/Verification of Information

I have read and accepted the eligibility requirements for covering dependents under the Archer & Greiner Plan. Moreover, I further attest that the legal dependent(s) I cover under the Plan meet the eligibility requirements. I understand that coverage for my enrolled dependent(s) will terminate when they no longer meet these eligibility rules. I further acknowledge that it is my obligation and responsibility to notify Benefits, in writing of any change in my dependent's status within 30 days of the event.

I understand that I may be randomly audited and required to submit proof of dependent status. Such audit may require that I supply necessary documentation, as determined appropriate, that shall be required to verify the eligibility of any dependent that is covered under my plan. I understand that such audits may take place at any time and that such audits are necessary for Archer Greiner to be able to properly satisfy and fulfill their obligations as the Plan Sponsor liable for administering the Plan of benefits pursuant it its terms.

I also understand that if it is subsequently determined that my dependent(s) does not meet the plan eligibility rules (other than those dependents I voluntarily remove), I may be considered to have falsified records and committed an act of "fraud" or "intentional misrepresentation" which will result in penalties. I understand that the Plan reserves the right to impose appropriate sanctions and recover losses resulting from coverage of ineligible dependents and that I may be subject to immediate adverse action that may include rescission of coverage, repayment of premium, repayment of claims, and possible termination of employment.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

DATE: _____

To be completed by the Benefits Department

_____

Date Received **Initials**

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