## BCBS Medical and Aetna Dental Plan
### Dependent Eligibility Matrix

<table>
<thead>
<tr>
<th>#</th>
<th>Dependent Type</th>
<th>Eligibility Criteria</th>
<th>Documents Required For Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spouse</td>
<td>• The person is currently your legal spouse (of the opposite sex excluding Common Law).</td>
<td>• A copy of your marriage license AND&lt;br&gt;• One form of dated (within 6 months) documentation establishing current marital status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, or front page of your 2011 jointly filed federal tax return (with blacked out financial information) or front page of your individually filed federal tax returns both showing current address.</td>
</tr>
<tr>
<td>2</td>
<td>Newlywed Spouse</td>
<td>• The person is currently your legal spouse (of the opposite sex excluding Common Law) AND&lt;br&gt;• You were married within the last six months.</td>
<td>• A copy of your marriage license.</td>
</tr>
<tr>
<td>3</td>
<td>Civil Union Partner</td>
<td>• The person is currently your Civil Union Partner (of the same or opposite sex) AND&lt;br&gt;• Resides with you on a full time basis.</td>
<td>• A copy of your civil union certificate AND&lt;br&gt;• Two forms of dated (within 6 months) documentation establishing current partnership status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, front page of both federal tax returns showing current common address (with blacked out financial information), assignment of durable power of attorney, or designation as a beneficiary of life insurance or retirement plan.</td>
</tr>
<tr>
<td>4</td>
<td>Natural Born Child</td>
<td>• Your natural born child AND&lt;br&gt;• Under age 26.</td>
<td>• A copy of the child's birth certificate naming you as the child's parent.</td>
</tr>
<tr>
<td>5</td>
<td>Natural Born Child</td>
<td>• Your unmarried natural born child AND&lt;br&gt;• The child is at least 26 years of age and until they turn age 30. AND&lt;br&gt;• Is a resident of the state of Illinois AND&lt;br&gt;• Has served as an active or reserve member of any branch of the Armed Forces and received a release of discharge other than a dishonorable discharge</td>
<td>• A copy of the child's birth certificate naming you as the child's parent AND&lt;br&gt;• DD Form 214 (Report of Separation) AND&lt;br&gt;• Proof of Residency</td>
</tr>
<tr>
<td>6</td>
<td>Natural Born Child</td>
<td>• Your natural born child AND&lt;br&gt;• The child is at least 26 years old AND&lt;br&gt;• A child who is physically or mentally incapable of self-support AND&lt;br&gt;• The incapacity occurred before age 26 as an eligible covered dependent.</td>
<td>• A copy of the child's birth certificate naming you as the child's parent AND&lt;br&gt;• Statement of Disability verified by insurance provider must be on file with Human Resources.</td>
</tr>
</tbody>
</table>
| Stepchild | • Your Stepchild  
AND  
• Under age 26. |
|-----------|--------------------------------------------------|
| Stepchild | • Verification of Spouse (See Spouse)  
AND  
• A copy of the child’s birth certificate naming your spouse as the child’s parent. |
|-----------|--------------------------------------------------|
| • At least 26 until they reach age 30  
• Received an honorable discharge from any branch of the U.S. Armed Forces | • Verification of Spouse (See Spouse)  
AND  
• A copy of the child’s birth certificate naming your spouse as the child’s parent.  
AND  
• DD Form 214 (Report of Separation)  
AND  
• Proof of Residency |
|-----------|--------------------------------------------------|
| Stepchild | • Your Stepchild  
AND  
• The child is at least 26 years old  
AND  
• A child who is physically or mentally incapable of self-support  
AND  
• The incapacity occurred before age 26 (as an eligible covered dependent) |
| • At least 26  
• Disabled | • Verification of Spouse (See Spouse)  
AND  
• A copy of the child’s birth certificate naming your spouse as the child’s parent.  
AND  
• Statement of Disability verified by insurance provider must be on file with Human Resources. |
|-----------|--------------------------------------------------|
| Legally Adopted Child or Child Placed for Adoption or Legal Guardianship | • Your Legally Adopted Child or Child Placed for Adoption or Child in Legal Guardianship  
AND  
• Under age 26. |
|-----------|--------------------------------------------------|
| • At least 26 until they reach age 30  
• Received an honorable discharge from any branch of the U.S. Armed Forces | • Amended Birth Certificate  
OR  
• A copy of adoption decree naming you as the child’s adoptive parent AND a copy of a legal document showing child’s age. |
|-----------|--------------------------------------------------|
| Legally Adopted Child or Child Placed for Adoption or Legal Guardianship | • Your unmarried Legally Adopted Child or Child Placed for Adoption or Child in Legal Guardianship  
AND  
• The child is at least 26 years of age and until they turn age 30.  
AND  
• Is a resident of the state of Illinois  
AND  
• Has served as an active or reserve member of any branch of the Armed Forces of the United States and received a release of discharge other than a dishonorable discharge |
| • At least 26  
• Disabled | • Amended Birth Certificate  
OR  
• A copy of adoption decree naming you as the child’s adoptive parent AND a copy of a legal document showing child’s age  
AND  
• DD Form 214 (Report of Separation)  
AND  
• Proof of Residency |
|-----------|--------------------------------------------------|
| Legally Adopted Child or Child Placed for Adoption or Legal Guardianship | • Your Legally Adopted Child or Child Placed for Adoption or Child in Legal Guardianship  
AND  
• The child is at least 26 years old  
AND  
• A child who is physically or mentally incapable of self-support  
AND  
• The incapacity occurred before age 26 as an eligible covered dependent. |
| • At least 26  
• Disabled | • Amended Birth Certificate  
OR  
• A copy of adoption decree naming you as the child’s adoptive parent AND a copy of a legal document showing child’s age  
AND  
• Statement of Disability verified by insurance provider must be on file with Human Resources. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A Child Covered by a NMSN or QMCSO</td>
<td>• A child covered under a National Medical Support Notice or a Qualified Medical Child Support Order.</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• A copy of the NMSN or QMCSO.</td>
</tr>
</tbody>
</table>

In all cases, the Summary Plan Description is the governing document with respect to eligibility.
BCBS Medical and Aetna Dental Plan  
Dependent Verification Affidavit

Member Name:

Reference Number:

Instructions

1. Please fill in the table below and refer to the "Dependent Eligibility Matrix" for eligible dependent types. Return only the signed Affidavit and supporting documents required by the Deadline Date.

   a. In Column A, all of your dependents enrolled in your BCBS Medical and Aetna Dental Plan should be listed. If any dependents are not listed, please add their names. (NOTE: Adding a name to the Dependent list DOES NOT add the dependent to your healthcare plan. You must contact Human Resources to add additional dependents.)

   b. If a dependent is eligible, in Column B, fill in the appropriate Dependent # / Type from the first column of the Dependent Eligibility Matrix and check the box in Column "C"

   c. In Column D, please remove any dependents that are no longer eligible under your plan.

   d. If you check the box in Column "D", fill in Column "E" for that row. This may determine whether this individual is eligible for COBRA continuation coverage.

Adding Dependents to the List Below Does Not Enroll Them in Any Health Care Coverage.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Name</td>
<td>Dependent Type (Insert # from Dependent Eligibility Matrix)</td>
<td>This dependent is eligible. I will provide the appropriate documents by the deadline.</td>
<td>This dependent is NOT eligible. This dependent will be dropped from coverage.</td>
<td>Last date of eligibility (if known)</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Member Name:

Signature: ____________________________ Date Signed: ____________________________

I hereby certify that the information provided is correct. I understand that any misrepresentation in the information provided will be considered fraud and/or an intentional misrepresentation of material fact as prohibited by the terms of the BCBS Medical and Aetna Dental Plan and will result in a rescission of coverage under the terms of the plan and applicable federal law. Furthermore, I understand that Rich Township High School District 227 may take other administrative and/or legal actions available under the terms of my employment or applicable law.