



Second Domiciled Adult-Affidavit of Eligibility

I, _____, submit this Affidavit to establish _____
(Name of Employee) (Name of Adult)

As my (check one)

- Unrelated Second Domiciled Adult (“Unrelated SDA”)
- Related Second Domiciled Adult (“Related SDA”) _____
(Relationship if Related SDA)

as defined below for the purpose of obtaining benefits that DePaul University may extend to employees’ Second Domiciled Adults.

Second Domiciled Adult’s _____ : _____ : _____
(Date of Birth) (SSN) (Address)

I also wish to cover his or her children:

Name of Child	Date of Birth	SSN	Gender	Address

And declare them to be eligible as defined below.

- I declare that my **Unrelated SDA** is eligible or benefits because we meet **all** of the following criteria:
 - We are not related in any way that would prohibit marriage;
 - Neither of us is legally married to any person;
 - Both of us are at least 18 years of age prior to the effective date of the coverage;
 - We have shared a principal residence at least 6 months prior to the effective date of the coverage (you may be considered to be residing together even if one or both leaves the shared residence for temporary reasons such as vacations, military service or education but intends to return);
 - We have a close personal relationship (not a casual roommate or tenant) that is intended to be permanent;
 - We share a mutual obligation of support and responsibility for each other’s welfare;
 - My SDA does not have any group health insurance; and
 - My SDA is not eligible for Medicare or Medicaid.

- I declare that my **Related SDA** is eligible or benefits because he or she meets **all** of the following criteria:
 - He or she is my parent, son, daughter, grandchild, great grandchild, grandparent, great grandparent, brother, sister, half-brother, half-sister, uncle, aunt, nephew, niece, mother-in-law, father-in-law, step-parent, or step-child;
 - Is at least 18 years of age prior to the effective date of the coverage;
 - Has shared my principal residence at least 6 months prior to the effective date of the coverage (you may be considered to be residing together even if one or both leaves the shared residence for temporary reasons such as vacations, military service or education but intends to return);
 - Does not have other group health insurance;
 - Is not eligible for Medicare or Medicaid; and

- Meets the criteria for tax-favored health benefits under the Internal Revenue Code
- I declare that my **SDA's child(ren)** is/are eligible or benefits because he/she/they meets **all** of the following criteria:
 - Is/are unmarried;
 - Is/are under age 23 (under age 26 for medical only);
 - Is/are the SDA's natural born, adopted or placed for adoption (meaning placed permanently with the SDA for adoption) child, stepchild, or a child for whom the SDA is the court-appointed legal guardian, or the SDA's disabled child (as defined below) of any age;
 - Has/have the same principal place of residence as the employee for more than six months of the year (temporary absences, such as for school, are treated as time in the same principal place of residence) and
 - Receive(s) more than one-half of his or her support from the SDA or from me.
- I agree to notify DePaul within 31 days of any change in the circumstances attested to in this Affidavit.
- I understand I may be responsible for payment of income taxes as result of DePaul providing benefits to my Unrelated SDA and his or her children.
- I will provide to the Plan Administrator or designated representative the following documentation to verify my SDA's eligibility:
 - Two recent documents that show my SDA's current address to be the same as mine, such as a driver's license, car or boat registration, tax return, lease, voter registration card, insurance policy, bank or brokerage account statement, utility bill, credit card bill, mortgage statement, pay stub, W-2 or 1099.

I am requesting to enroll my SDA and children of an SDA in the following health plans.

Plan	Enroll SDA	Enroll SDA child(ren)
Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you are enrolling your SDA and or SDA child(ren) in Dependent Life, please choose one of the following coverage options.

Dependent Life	<input type="checkbox"/> \$20,000/\$10,000 coverage	<input type="checkbox"/> \$10,000/\$5,000 coverage
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If you are enrolling your SDA and or SDA child(ren) in Dependent Life, you will need to fill out an Evidence of Insurability form located on the Human Resource website at <http://hr.depaul.edu>. The form must be submitted to the Standard Insurance Company within 31 days from your qualified event.

By signing below, I affirm that the assertions in this Affidavit are true to the best of my knowledge. Further, I understand that providing false or misleading information in this Affidavit may result in any or all of the following actions by DePaul University:; a requirement that I reimburse DePaul for all health claims, administrative and legal expenses; termination of my employment; and other legal action against me.

_____ (Signature of Employee) _____ (Employee ID Number) _____ (Date)

HR representative signature _____ Date Processed _____