Dependent Eligibility Affidavit

Use this form to certify that the dependents you will be covering under your medical, dental, and/or vision insurance plan(s) meet the eligibility requirements for the plan(s).

The following dependents can be covered on your medical and/or dental plan(s) without potential tax consequences:

- Your spouse
- Your children under age 26
- Your disabled children

The following dependents can be covered under your plan(s), but if they do not qualify as your IRS dependent you may be responsible for paying taxes on the value of their coverage. You will be asked to provide additional information verifying tax status of these dependents:

- Your former spouse
- Your domestic partner
- Your domestic partner's children who are
  - Under age 26
  - A disabled dependent

This tax information is not intended as tax advice, but rather to alert you of potential tax ramifications and IRS rules. It is recommended that you consult with a qualified tax advisor to fully understand the tax issues around covering dependents on your medical and/or dental plans. You may also review IRS Publication 17 to find detailed information on the IRS definition of a dependent.

Employee Name _____ Social Security Number _____

I certify that the following dependents are eligible to be covered under my medical, dental, and/or vision plan(s).

Spouse/Domestic Partner/Former Spouse

Name _____ ☐ Spouse ☐ Domestic Partner ☐ Former Spouse

Dependent Children – please attach a second form if more space is needed

Name _____

Name _____

Name _____

Name _____

Name _____

IMPORTANT – PLEASE READ, PRINT AND SIGN

I certify that the information I have provided is true and accurate. I understand that if there is any misrepresentation in the information I have provided, Tufts Health Plan may end my dependent's coverage as well as my entire family's coverage, and may seek any other legal remedies available. I also understand that if I or any of my enrolled dependents obtain a health care benefit or payment that I know I or they are not entitled to receive or be paid, or knowingly with intend to defraud Tufts Health Plan file an application or claim for insurance containing any materially false information, I can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including the cost of investigation. I further agree to notify Tufts Health Plan immediately of any changes in dependent status.

Employee Signature _____ Date _____