HS

BTT Use Only
Event Date _____
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University of Michigan

Application for Principally Supported Child and Employee Certification

To enable the University of Michigan to determine the eligibility of the dependent child you have identified as a principally supported dependent, the following information is needed. Enrollment of this individual cannot be completed until the status of this dependent has been verified and approved. Please print all information in **black ink**.

1. U-M Faculty or Staff Member Information

Name (Last, First, Middle Initial)		UMID	U.S. Social Security Number (If UMID is unknown)
Street Address		City, State, ZIP	
Home Phone Number	Daytime Phone Number	Email Address	

2. Dependent Child Information

Name (Last, First, Middle Initial)		Date of Birth	U.S. Social Security Number
Gender ☐ Male ☐ Female	Dependent's Relationship to Employee	Dependent's Marital Status ☐ Single ☐ Married ☐ Divorced	
Dependent began legally residing with you on (date):	Has dependent lived with you continuously since that time? ☐ Yes ☐ No If no, explain:		

Dependent's Income Tax Status

a) Did you claim this dependent as an eligible dependent exemption on your most recent Federal Income Tax filing? ☐ Yes ☐ No

b) If no, would the dependent qualify to be claimed? ☐ Yes ☐ No If no, explain: _____

c) Will you claim this dependent as an eligible dependent exemption when filing your Federal Income Tax for the current year? ☐ Yes ☐ No

d) If no, would the dependent qualify to be claimed? ☐ Yes ☐ No If no, explain _____

e) Has anyone else claimed this dependent for Federal Income Tax purposes? ☐ No ☐ Yes If yes, for each tax year, identify name of the tax filer and their relation to this dependent.

Name of tax filer claiming this dependent	Tax Filer's relation to Dependent	Tax Year Claimed

3. Certification and Signature

Must be completed by all applicants. Please read "Terms and Conditions" on the reverse side before signing.

I certify under penalty of perjury that the statements made by me in this Application and Certification are true and correct to the best of my knowledge. Further, I have read and understand the reverse side of this form and agree to the terms and conditions listed there.

Faculty or Staff Member Name (please print) _____

Faculty or Staff Member Signature _____

Date Signed _____

Application for Principally Supported Child and Employee Certification

Terms and Conditions

IRS Section 125 Restrictions

Dependents can only be added or deleted mid-year if a family status change occurs which is consistent with the benefits change that is being made. Notify the Benefits Office of the family status change by completing the required forms within 30 days of the event. If you fail to notify the Benefits Office within 30 days of the event, you must wait until the next Open Enrollment in which you are eligible to participate to make the change. Family status changes include marriage, divorce, the birth or adoption of a child, death of a dependent, or a change in employment status (for you, your spouse or other qualified adult), such as a leave of absence without salary, a job termination or new job commencement.

1. I understand my principally supported dependent must be:
   - Related to me by blood or marriage, and
   - Under 19 years of age, and
   - Unmarried, and
   - A member of my household on a full-time basis

2. I certify that this child is dependent upon me for more than half of his/her support as defined by the Internal Revenue Code and has been claimed on my most recent Federal Income Tax return, or will be claimed on this year's Federal Income Tax return if the child began living with me after the last tax return was filed.

3. I certify I have supported the child for at least six consecutive months before making this application.

4. I understand the child's coverage will go into effect the first of the month following 90 days after my application is received and approved by the Benefits Office.

5. I agree to furnish proof of my dependent's continued eligibility whenever required by my insurance carrier or the university.

6. Upon request, I will furnish a copy of the section of my IRS Form 1040 listing dependents, court orders establishing guardianship or adoption, and/or the birth certificate of any individual for whom I seek benefits.

7. If there is any change in the status of any of the individuals listed on this form, I will be responsible for notifying the university within 30 days of such change.

8. By my signature on this form, I certify that I understand and I affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences, including loss of benefits, discipline or appropriate legal actions.

Release of Information

The Benefits Office will not release any information about you except:
(1) when you request it in writing, or
(2) when the release is necessary to process or review a claim (for example, to another insurance company).

If requested to do so, the Benefits Office will notify you of the information released and to whom.

Important Notice

You cannot cover under your University of Michigan benefits plans:
(1) Anyone who works for the University and has his or her own coverage as an employee of the University;
(2) Any dependent child who works for the University and is eligible for benefits as an employee of the University.
(3) Any eligible dependents who are already covered by another employee of the University, unless you are court-ordered to provide such coverage;
(4) Anyone who is not your legal spouse, same-sex domestic partner or eligible dependent;
(5) Yourself if you are covered by another University of Michigan employee in the same plan.

When you sign this change form, you confirm that you understand and agree that claiming such coverage is misconduct, and you agree to reimburse the university for any additional costs incurred as a result of that misconduct.

Authorization

You authorize any doctor, hospital or other provider rendering service to you or your dependents to furnish to the plan you have selected any information requested concerning medical information, claims and other insurance payments.

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?
If you have any questions, view the Benefits Office website at benefits.umich.edu, or call the SSC HR Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.).

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-763-0363.
Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **Campus Mail or U.S. Mail** to:
SSC Benefits Transactions
Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1276