

Definition of a Dependent

Listed below are the definitions of a dependent based upon the guidelines of Kent State University's benefit plans.

Spouse: Your legal spouse.

Domestic Partner: The employee's same-sex or opposite-sex registered domestic partner.

Child: A biological child, stepchild or adopted child of the employee or the employee's spouse or registered domestic partner who is under the age of 26. A dependent child for whom the employee, the employee's spouse or registered domestic partner has legal guardianship or legal custody.

Disabled Child: The maximum dependent age limits do not apply for a child who cannot hold a self-supporting job due to a permanent physical disability if:

- The child becomes disabled prior to age 19 and remains disabled while covered under the medical plan(s).
- The physical or mental impairment is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

Kent State University Dependent Eligibility Rules and Documentation Requirements

The chart below shows each category of a dependent as defined by the Kent State Medical Plan and lists the supporting documentation that you are required to submit along with the completed form.

CATEGORY OF DEPENDENT	SUPPORTING DOCUMENTATION
Spouse as defined above	Marriage certificate
Registered domestic partner	Affidavit of Domestic Partnership including supporting documents
Biological child, stepchild under the age of 26	Birth certificate listing parents
Adopted child or dependent child for whom the employee, employee's spouse, or employee's registered domestic partner has legal guardianship or legal custody	Birth certificate and court order recognizing adoption, legal custody or guardianship/placement.
Unmarried disabled child over the age of 26, if approved as incapacitated under the health plan	Birth certificate listing parents and copy of approval letter from medical carrier for a disabled status under the medical plan

Kent State University Benefit Plans Dependent Eligibility Verification Form

Instructions for Completion:

Please list all dependents that you would like to enroll in the benefit plan(s). **PRINT CLEARLY, in INK** in the spaces provided. Sign and return this form with **COPIES** of the supporting documentation to the **University Benefits Office – Located second floor of Heer Hall, Kent Campus.**

Banner ID Number	Campus	Employee Last Name	Employee First Name	Employee Telephone	Employee Gender (circle one)	Employee Date of Birth
				(____) ____-____	Male / Female	___/___/___

Street Address	City	State	Zip Code

Add To Coverage	Social Security Number	Last Name	First Name, MI	Date of Birth (xx-xx-xxxx)	Gender (M/F)
Spouse/Domestic Partner					
Child-1					
Child-2					
Child-3					
Child-4					
Child-5					
Child-6					

REMINDER: YOU MUST ATTACH COPIES OF SUPPORTING DOCUMENTATION TO COMPLETE THE PROCESS. FAILURE TO RETURN THE REQUIRED INFORMATION WITHIN THE 30-DAY DEADLINE MAY RESULT IN SUSPENSION OF BENEFITS UNTIL SUCH INFORMATION IS SUPPLIED.

I certify that the information provided is complete, correct, and up-to-date. I understand that any misrepresentation could result in disciplinary action up to and including termination of employment.

Signature _____

Date Signed _____

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