DEPAUL UNIVERSITY
OFFICE OF HUMAN RESOURCES

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")

☐ Civil Union Spouse

☐ 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) (Gender) (Address)

I also wish to cover my SDA's child(ren):

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 for 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 share a principal residence and have shared a principal residence for at least the 6 months immediately prior to the effective date of the coverage (you may be considered to be residing together even if one or both leave the shared residence for temporary reasons such as vacations, intermittent business travel, 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

☐ I declare that my **Related SDA** is eligible for 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;
- He or she is at least 18 years of age prior to the effective date of the coverage;
- He or she shares my principal residence and has shared my principal residence for at least the 6 months immediately prior to the effective date of the coverage (you may be considered to be residing together even if one or both leave the shared residence for temporary reasons such as vacations, intermittent business travel, military service or education but intends to return);
- He or she does not have other group health insurance;
- He or she is not eligible for Medicare or Medicaid; and

- He or she is my qualifying child or qualifying relative. Refer to the Declaration of Tax Status for additional details.

☐ I declare that my **SDA's child** is eligible for benefits because he/she meets **all** of the following criteria:
- Is unmarried;
- Is under age 26 (under age 23 for dental and/or vision), or any age if disabled as defined in the Health Benefits Plans SPD;
- Is 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;
- Lives with me for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence); and
- Receives more than one-half of his or her support from me or my SDA.

Note: For enrollment in the dental and/or vision plans, in addition to the criteria above, the child of an SDA must be considered your tax dependent for health coverage purposes under the Internal Revenue Code. Refer to the Declaration of Tax Status for additional details.

☐ I agree to notify DePaul within 30 days of any change in the circumstances attested to in this Affidavit.

☐ I understand that I may be responsible for payment of income taxes as a result of DePaul providing benefits to my Unrelated SDA and his or her children, and I understand that I may be required to pay the cost of coverage for my Unrelated SDA and his or her children on an after-tax basis.

☐ 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; or
- My Civil Union Certificate in lieu of the above documentation.

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	☐ Yes ☐ No	☐ Yes ☐ No
Dental	☐ Yes ☐ No	☐ Yes ☐ No
Vision	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Life	☐ Yes ☐ No	☐ Yes ☐ 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	☐ $20,000/$10,000 coverage	☐ $10,000/$5,000 coverage

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*_____