Dependent Verification Form
Dental and/or Vision Insurance Benefits

Employee Name: (Please Print)_____

Address: _____

E-mail: _____ Phone: _____

Social Security Number:_____

Check one of the following:

☐ Coverage is for a Legal Spouse (refer to **Section #1**)
☐ Coverage is for a Domestic Partner (refer to **Section #2**)

Section #1

If coverage is for a Legal Spouse you must provide a marriage certificate within 14 days of receipt of this letter. Return Page #1 along with your marriage certificate to A-1. If we do not receive the marriage certificate within 14 days, coverage will not be provided to your spouse.

Section #2

A Domestic Partner is eligible for A-1's group dental and vision insurance if they meet the following criteria. If we do not receive the supporting documentation within 14 days, coverage will not be provided to your Domestic Partner.

1. We have an exclusive mutual commitment, similar to that of marriage, but are not legally married.
2. We are each other's sole domestic partner and intend to remain so.
3. Neither of us is legally married.
4. We are not related by blood.
5. We are both at least eighteen (18) years of age.
6. We are currently residing together and have resided together in a common household for at least (12) consecutive months and intend to reside together.
7. We share joint responsibility for our common welfare and financial obligations and able to demonstrate such obligations by providing documentation:

    a) At least four items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable property or health care power of attorney, co-parenting agreement, or an adoption agreement.

Section #2 (continued)

1. Domestic partners and their dependents are subject to the same plan guidelines, which govern all other participants in the employer's vision and dental benefit program. The plan documents and the insurance contracts govern all questions of coverage.

2. The dental and vision provider reserves the right to request proof that the domestic partnership meets the eligibility requirements set forth above. I agree to provide the employer supporting documents to determine eligibility domestic partner status.

3. If there is any change in our status as domestic partners as certified in this application, I will notify in the writing the employer within sixty (60) days of such a change. If this change results in a termination of the domestic partnership status upon receiving such notification of termination, the domestic partnership status will be terminated as of the date the termination request is signed.

4. I understand upon cancellation of coverage, domestic partners are not considered qualified beneficiaries and COBRA benefits will not be extended to domestic partner losing coverage.

For Domestic Partner Coverage You Must Complete and Sign:

I wish to enroll:

- ❑ My domestic partner in the employer-sponsored insurance.
- ❑ My domestic partner and dependent children in the employer sponsored insurance.

You must submit the supporting documentation in order to provide coverage for your Domestic Partner and eligible children (if applicable):

(Must select FOUR out of the SIX documents)

- ❑ Joint Credit Documentation
- ❑ Joint Lease Agreement/Mortgage Deed
- ❑ Joint Bank Account Statement (s)
- ❑ Copy of Joint Household expenses responsibility
- ❑ Power of Attorney
- ❑ Other (Joint financial responsibility) _____

I affirm the statements made above are true and are complete to the best of my knowledge and I understand that false statements and/or the failure to notify the employer of any changes in status can result in disciplinary action.

_____ _____

Employee Signature Please Print Name

_____ _____

Date Social Security Number

Send to: A1HR Benefits Department 3829 Coconut Palm Drive, Tampa, Florida 33619

Office Number (813) 620-1661 / Toll Free Number (877) 636-1661 / Fax Number (813) 490-1191