CalPERS

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California Public Employees' Retirement System

Sample: Dependent Re-verification Affidavit

At least once every three years, California Government Code Section 22843.1 and California Code of Regulations Section 599.855 require your employer to re-verify the eligibility of your dependent(s). This Affidavit is required to be completed by the Subscriber. This document must be completed, and copies of the required documentation noted below must be provided to your department's personnel office.

SECTION A: Subscriber Information

Subscriber Name: {Subscriber Name} **Subscriber CalPERS ID:** {CalPERS ID}

SECTION B: Dependent(s) Requiring Re-verification

Only the dependent(s) listed below are required to be re-verified:

Dependent Name	Relationship	Date of Birth
{Dependent Requiring Re-verification}		
{Dependent Name}	{Relationship}	{DOB}
{Dependent Name}	{Relationship}	{DOB}

SECTION C: Required and Acceptable Re-verification Documents

Review the table to assist with the required and acceptable documentation needed to re-verify each dependent's eligibility. All required documents **MUST** include a date, your name, and the name of the dependent being re-verified.

<table>
<tr><th>Relationship Type</th><th>Acceptable Re-verification Documents</th></tr>
<tr><td>Spouse</td><td>A copy of your government issued marriage certificate AND one of the following financial documents:
A copy of the first page of the most recent federal or state income tax return form confirming dependent as your spouse
OR
A combination of other documentation, including but not limited to a household bill, account statement, or insurance policy listing the name and address of the subscriber and the spouse, or other documents that substantiate the existence of a current marriage. Household bills and account statements older than 60 calendar days are unacceptable</td></tr>
<tr><td>Domestic Partner</td><td>A copy of your Declaration of Domestic Partnership registered with the California Secretary of State or a comparable agency in another jurisdiction AND one of the following financial documents:
A copy of the first page of the most recent federal or state income tax return form confirming dependent as your domestic partner
OR
A combination of other documentation, including but not limited to a household bill, account statement, or insurance policy listing the name and address of the subscriber and domestic partner, or other documents that substantiate the existence of a current domestic partnership. Household bills and account statements older than 60 calendar days are unacceptable</td></tr>
<tr><td>Children (natural-born, adopted, step, or registered domestic partner's children) up to age 26 (the month in which dependent attains age 26)</td><td>A copy of the child's birth certificate or adoption certificate naming you, your spouse, or your domestic partner as the parent of the child.

For a stepchild, or domestic partners child, you must also provide documentation of your current relationship to your spouse or domestic partner as requested.</td></tr>
</table>

SECTION D: Initial and Signature of Subscriber

The Subscriber must sign and date.

I hereby certify under penalty of perjury:

I understand the eligibility requirements described in this document and that all information provided by me is true and correct to the best of my knowledge.

I provided the required documentation to substantiate the relationship of my enrolled dependent(s).

I understand that additional information and supporting documentation may be requested as necessary to substantiate dependent eligibility for health benefits.

I agree to notify my employer in writing within 60 days upon the dissolution of a marriage, domestic partnership, or when a change in dependent(s) eligibility occurs.

I agree that I am responsible for ensuring that the health enrollment information for myself and my dependents is accurate. If I do not maintain accurate health enrollment information, I may be liable for reimbursement of health premiums or health care services incurred during the ineligibility period.

Subscriber Name: __________________ Subscriber CalPERS ID: _______________

Subscriber Signature: ________________________ Date: ______________

SECTION E: Employer Authorization

For Employer Use Only

This section must be signed and dated by the personnel office's Human Resources Representative.

I hereby certify that:

I am a duly appointed and qualified representative of the agency/department.

I have reviewed the employee's supporting documents to re-verify the dependent(s) eligibility.

I informed the employee they are required to notify their employer in writing within 60 days upon the dissolution of a marriage or termination domestic partnership, when a parent-child relationship ceases, or a change in dependent(s) eligibility occurs.

I informed the employee they may be required to reimburse their employer, the health, dental, or vision benefit plan, and CalPERS for expenditures made for medical claims, or health premiums incurred during the ineligibility period of any dependent if any of the submitted documentation is found to be inaccurate or fraudulent and that a review of eligibility can occur at any time.

I retained copies of the employee's health, dental, and vision enrollment form(s) and all supporting documents to re-verify eligibility of employee dependent(s) in the employee's Official Personnel File.

I will provide a copy of this completed affidavit to the employee.

Based on the information provided and review of the documentation, I am approving the enrollment of such dependent(s).

HR Representative Name: ______________________ Job Title: ________________

HR Representative Signature: ________________________ Date: _____________

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested by CalPERS' Information Security Office is collected pursuant to the following authority:

- CA Civil Code §56.10
- CA Civil Code §56.11
- CA Civil Code §56.13
- 45 C.F.R. §164.508

The principal purpose the information will be used for is the administration of duties under the Health Insurance Portability and Accountability Act (HIPAA), as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to process your request.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers (SSN) are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided to CalPERS, disclosure is voluntary. Due to the use of SSNs by other agencies for identification purposes, we may be unable to process your request without its disclosure.

Social Security numbers are used for the following purposes:

1. Member / Representative identification
2. Fulfill Member / Representative requests

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy (https://www.calpers.ca.gov/page/privacy-policy), or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).