INDIANA UNIVERSITY

UHRS 12/2011

Termination of Tax-Qualified Dependent Status

Complete and submit to University Human Resource Services (Attn: COBRA Specialist, Poplars E165, IU Bloomington)

EMPLOYEE INFORMATION:

Employee Name (Last, First, MI): ______________________ 10-digit ID: __ __ __ __ __ __ __ __ __ __

Date of Birth: _____/_____/________ Gender: ______________ Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: ______________________ City: ______________ State: ________ Zip: ____________

DOMESTIC PARTNER INFORMATION:

Domestic Partner Name (Last, First, MI): ______________________Partnership Began On: _____/_____/________

Date of Birth: _____/_____/________ Gender: ______________ Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: ______________________ City: ______________ State: ________ Zip: ____________

DOMESTIC PARTNER DEPENDENT CHILD INFORMATION:

List only the domestic partner's child(ren) who were listed on the original Affidavit of Same-Sex Domestic Partnership.

Name (Last, First, MI): ______________________ SSN: __ __ __ - __ __ - __ __ __ __ DOB: ____/____/_______ RC: ___ ___

Name (Last, First, MI): ______________________ SSN: __ __ __ - __ __ - __ __ __ __ DOB: ____/____/_______ RC: ___ ___

Name (Last, First, MI): ______________________ SSN: __ __ __ - __ __ - __ __ __ __ DOB: ____/____/_______ RC: ___ ___

Name (Last, First, MI): ______________________ SSN: __ __ __ - __ __ - __ __ __ __ DOB: ____/____/_______ RC: ___ ___

RC (Relationship Code): DS = biological or adopted son of domestic partner
DD = biological or adopted daughter of domestic partner

CERTIFICATION

This certifies that as of ____________________ (date) the above person or persons no longer qualifies as my legal tax dependent under IRS Section 152.

I further understand that the dependent's eligibility for Indiana University sponsored benefits ends on the date the dependent no longer meets Indiana University's eligibility requirements as outlined at ***hr.iu.edu/benefits/needknow.html***. Failure to notify the university within 30 days of the termination date may result in liability for benefits paid for ineligible individuals, and disciplinary action (including cancellation of the employee's health plan coverage or termination of employment). In the case of a domestic partner or associated child covered under an Indiana University sponsored health care plan, failure to provide timely notice to the university jeopardizes COBRA health care continuation coverage. COBRA coverage must be elected within 60 days of the termination of the tax dependent's health care coverage.

I certify that the information supplied on this form is true and complete, and I understand that any false information or statements made on this form will be grounds for Indiana University to void my coverage and/or terminate my employment.

Employee Signature: ____ Date: _____/_____/________

FOR UHRS USE ONLY

Received and approved by: ____ Date: _____/_____/________