Heluna Health
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

Dependent Attestation Form
Plan Year: August 1, 2024 – July 31, 2025
(Medical, Dental, Vision Plans only)

Employee Name:	Employee Number:

Section A: Dependent Eligibility Attestation

To enroll a qualified dependent in the Heluna Health's medical, dental and vision benefits, you are required to complete, sign and return this Dependent Eligibility Attestation form within 30 days of enrolling your dependents. If you have any questions about dependent eligibility status, you may contact the Benefits Department at benefits@helunahealth.org.

- The Plan has the right to request reimbursement of any premiums and claims paid for ineligible dependents.
- Employees enrolling ineligible participants may be subject to disciplinary action - including termination of coverage for benefits.
- Heluna Health reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse, domestic partner and/or dependent child(ren).

Eligible Dependents Include (please check all that apply):

- ☐ Legal spouse
- ☐ Domestic partner
- ☐ Children (birth to age 26)
  - Biological child(ren)
  - Adopted child(ren)
  - Stepchild(ren)
  - Foster children if you or your Spouse have the legal authority to direct their care
  - Legal ward child(ren)
- ☐ Disabled dependent child(ren) over the age of 26 (proof of disability must be provided)
- ☐ Domestic partner's child(ren)

I certify that the information I have provided above is true and all dependents enrolled in coverage meet the definition of Eligible Dependents.

Employee Signature	Date

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Section B: Other Coverage Attestation (Medical only)
This section is required to be completed for coordination of benefits purposes. Please review, complete and return to the Benefits Department.

Spouse/Domestic Partner enrolled in other coverage:

- ○ Employer-sponsored group health plan with minimum essential coverage through his/her employer
- ○ Employer-sponsored group health plan with minimum essential coverage under his/her parent's plan
- ○ School Health Plan
- ○ Medicare select best option that applies
- ○ VA
- ○ TRICARE
- ○ Medicaid (Medi-Cal)
- ○ Covered CA or Marketplace Exchange health plan
- ○ Individual (Off Exchange) health plan
- ◉ Other (please specify)_____

Child(ren) enrolled in other coverage:

- ○ Employer-sponsored group health plan with minimum essential coverage through my spouse
- ○ School Health Plan
- ○ Medicaid (Medi-Cal)
- ○ Covered CA or Marketplace Exchange health plan
- ○ Individual (Off Exchange) health plan
- ○ Other (please specify)_____

Please note: your qualified spouse/domestic partner may not be eligible to enroll in a Heluna Health medical plan if they are enrolled in Medicare (Part B or Part C), Medicaid/Medi-Cal or Marketplace Exchange health plan with subsidy. You cannot change or terminate dependent coverage outside of the annual open enrollment unless you are experiencing a valid Qualifying Life Event.

Employee Signature Date

Any person who knowingly presents a false or fraudulent claim or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to termination of employment as well as prosecution, fines and imprisonment.