

Northern Kentucky University - Confidential

Affidavit of Qualifying Adult (Extended Family Member) for Benefit Coverage

Employee Information

Employee Name (Last, First, Middle):				
Date of Birth:	Phone	Employee ID:		
Address:		City:	State:	Zip Code:

Qualifying Adult Information

Qualifying Adult Name (Last, First, Middle):		
Date of Birth:	Gender (Circle One): M F	Relationship to Employee:
<i>The portion of premium associated with the EFMember's benefit coverage is withheld on an after-tax basis from the NKU employee named above and imputed income is reported for taxation on the value of said premium.</i>		Note: An employee may cover his/her legal spouse OR one qualifying adult on his/her NKU medical plan, but not both.

Declaration

<p>We, the undersigned, certify that the Qualifying Adult named above:</p> <ul style="list-style-type: none"> ▪ Is age 18 or older and mentally competent to consent, and ▪ Is either not related to you (the employee) by blood, or if a blood relative (or relative by adoption or marriage) is of the same or younger generation of the employee (as used in KRS 391.010), and ▪ Is not legally married to anyone, and ▪ Is not currently eligible for any part of Medicare, and that ▪ We share a residence and have done so for at least twelve consecutive months prior to this declaration, and that ▪ We are jointly responsible for each other's financial obligations which could be demonstrated upon request by providing proof of existence of at least one of the following (please check): <ul style="list-style-type: none"> <input type="checkbox"/> A joint mortgage or lease or other evidence of common residence such as joint utility bills <input type="checkbox"/> Durable property or health care power of attorney <input type="checkbox"/> Joint ownership of a motor vehicle <input type="checkbox"/> Joint checking account/credit account <input type="checkbox"/> Designation of each other as the primary beneficiary in a will, life insurance policy, or retirement plan <p>I agree to notify the university within 30 days if any eligibility requirements listed above are no longer satisfied which would make the qualifying adult no longer eligible for coverage.</p> <p>We certify that the information included here is true and correct and understand that a false declaration of a qualifying adult or failure to file a timely termination notice with the university if this qualification ends may result in disciplinary action up to and including termination of employment at Northern Kentucky University. We agree that in the event of a false declaration, or the failure to file a timely termination notice if this eligibility ends, the university may recover damages from either or both of us for all costs and expenses incurred by the university as a result of that false declaration, including, without being limited to, attorneys' fees incurred by the university to recover such damages. See university policy PER 5.01.</p>			
Employee Signature	Date	Qualifying Adult Signature	Date
Notarized by:		Commission Expires On:	
_____ Signature/Print Name & Jurisdiction		_____	

