

Application/Affidavit to Establish Dependency by Guardianship

IU-Sponsored Healthcare Plans

A copy of the Guardianship Order must be attached to this application/affidavit. Submit completed application and required documentation to your campus Human Resources office.

Employee Information:

Employee Name: _____ Date of Birth: ____/____/____ 10-Digit Employee ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Campus: _____ Phone: _____ - _____ - _____ E-mail: _____

Child's Information:

Child's Name: _____ Date of Birth: ____/____/____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Guardianship Eligibility Guidelines:

In order for the above listed child to qualify as an eligible dependent, the following guidelines must be met:

- 1) The guardianship of the child must be established by a currently valid court order in the United States.
- 2) The guardianship of the child must be for an unlimited period of time;
- 3) The employee and/or eligible spouse must be the sole guardian of the child and no other individual(s) may share financial or parental responsibility for the child.
- 4) The guardianship must be as a result of the child having no parent capable of caring for the child.
- 5) The employee and/or eligible spouse must be the sole means of financial support for the child (other than support from governmental agencies or programs);
- 6) The child must be a citizen, national, or resident of the United States or of a country contiguous to the United States.

Court in which guardianship was ordered: _____ Effective Date of Order: ____/____/____

Other than this guardianship, are you related to this child? Yes No If Yes, Relationship to Child: _____

Will the child be your tax dependent? Yes No If No, Explain: _____

Reason the parent(s) no longer have custody of the child:

- Child has lost both parents through death.
- Child has been abandoned by the parents.
- The parents' rights to the child have been taken away through the court or government agency.
- Parents are not physically or mentally able to care for the child due to disability or other cause.

Please Explain: _____

Other: _____

Employee Certification:

I hereby certify that the above listed child meets IU's guidelines for dependent eligibility through guardianship. I understand that I must notify IU within 30 days of any change in the status of this guardianship or any other change in status (e.g. marriage, or financial support) that would make the child ineligible for IU-sponsored health care benefits. I understand that any false information or statements made on this form will be grounds for IU to void my coverage and/or terminate my employment.

Employee Signature: _____ Date: ____/____/____