CalPERS

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California Public Employees' Retirement System

Dependent Verification Affidavit

At least once every three years, California Government Code Section 22843.1 requires your employer to 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 agency's personnel office.

SECTION A: Subscriber Information

Subscriber Name: **Subscriber CalPERS ID:**

SECTION B: Dependent(s) Requiring Verification

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

Dependent Name	Relationship	Date of Birth

SECTION C: Required and Acceptable Verification Documents

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

Relationship Type	Acceptable Verification Documents
Spouse	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, confirming the 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 you and your spouse. Household bills and account information older then 60 calendar days are not acceptable.
Children up to age 26 (the month in which dependent attains age 26) - Natural-born - Adopted - Step-Children - Domestic partner's children	- 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 step child, or domestic partner's child, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

SECTION D: Initial and Signature of Subscriber

Every statement within this section below must be initialed by the 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 or dental 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 a dependent's eligibility occurs.

_____ I agree that I am responsible for ensuring that my health enrollment information for myself and my family members 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 initialed, 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 verify each 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 of domestic partnership, when a parent-child relationship ceases, or a change in a 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 family member 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 verify eligibility of the employee's 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 is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

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

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

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, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).

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