Re: Certification of Dependent Children

The University of Iowa is required to collect information for all covered dependents age 26 or older to verify they are eligible to be covered on their parent’s benefit plan(s) subject to the applicable rules and regulations, and to determine if a tax on the fair market value of the dependent coverage applies. On the following page, please check either ‘yes’ or ‘no’ for all of the items listed for each of your covered dependents age 26 or older, then sign below and return this form to the University Benefits Office within 30 days of the enrollment.

Only certain individuals may receive medical and dental coverage on a tax-favored basis. If your child does not qualify as your tax dependent per IRS rules, you will be taxed on the fair market value of the coverage. The excess value will be included in your gross income. Please see the University Benefits Office website for more information on this.

If we do not receive this completed form by the required date, or if your responses indicate a dependent does not meet eligibility requirements, we will remove the applicable dependent(s) from coverage. You will not be able to add them to your coverage again until the next open enrollment, if they are eligible at that time, unless there is a qualifying event.

To the best of my knowledge, all statements and answers provided are complete and true. I understand that fraud or a material misrepresentation regarding a dependent’s eligibility for coverage could result in discipline up to and including termination. I will be responsible for the cost of services provided during the period when coverage was in effect at the time the dependent became ineligible.

Signature: ___________________________ Date: ____________________

Return this form to:
University Benefits Office
120 University Services Building
Iowa City, IA 52242-1911
Fax: 319-335-2776
E-mail: benefits@uiowa.edu

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CERTIFICATION OF DEPENDENT CHILDREN 26 OR OLDER

Respond to all four items for each dependent age 26 or older

Dependent Name: ___________________________ Date of Birth: ________________

___ Yes ___ No: This child is a full time student. If yes, list school: ____________________________

___ Yes ___ No: This child is married.

___ Yes ___ No: This child qualifies as my tax dependent for income tax purposes for 2017.

___ Yes ___ No: This child is disabled.