

IMPORTANT HEALTHCARE BENEFITS INFORMATION
****ACTION REQUIRED****

<Employee name >
<Address>

<date>

Dear <insert name>:

Many efforts have already been enacted to try to reduce the ever-rising increases in health care costs for Miami University. From Miami's Health and Well-being program to signing with a new healthcare insurance provider to employees who are making better health care decisions, all efforts make a difference. Now, the human resources office (HR) seeks to enhance its records to be sure appropriate care is being provided.

We ask your help in this effort.

Miami University's Benefits Committee set a goal this year to reduce the anticipated health care cost increase by \$500,000 to \$1,000,000. The primary action we identified to meet this goal is a review of the eligibility of dependents. Miami University has hired the consulting firm Hauser Corporate Solutions (HCS) [no relation to Carol Hauser in HR] to help verify that all dependents covered under Miami University health, dental and vision plans are eligible to receive benefits according to plan terms.

HCS is collecting the documentation requested in this letter from all Miami University employees who have family members enrolled in Miami University's health, dental and/or vision plans. HCS will use the documentation you provide to verify that each of your enrolled dependents is eligible to receive benefits.

We need for you to provide the appropriate documentation described later in this packet by **August 17, 2009**.

Your confidentiality and privacy will be protected throughout this process.

To ensure that all of your dependents who are eligible remain covered under any Miami University health, dental or vision plan, documentation *must* be provided. For the majority of employees, this will only require providing HCS with a copy of a marriage certificate or a birth certificate. The description of eligible dependents and the required documentation begins on page 5.

If documentation for any dependent is not provided, Miami University will consider this your acknowledgement that the dependent is not eligible and coverage for that dependent will end August 31, 2009. If you later determine that the dependent is in fact eligible and you would still like to cover them under the Miami University health, dental or vision plans for the remainder of

the 2009 Plan year, you may still provide documentation to HCS to certify eligibility. Once documentation has been received, your dependent(s) will be added back to coverage on the first of the month following the date you provide all the required documents.

Thank you in advance for your cooperation. Together, we will work toward appropriate health care coverage and maintaining insurance costs for all of us.

Sincerely,

A handwritten signature in cursive script that reads "Carol Hauser". The signature is written in black ink on a light-colored background.

Carol Hauser
Senior Director, Human Resources

Enclosed in This Packet:

1. **Description of Eligible Dependents** – This page describes who is considered an eligible dependent under your Health, Dental and Vision plans and shows you what documentation is required to verify continuing eligibility of your dependents and the resources you might be able to use to obtain the documents required.
2. **Dependent Verification Form for Eligibility Certification** – This form lists the dependents currently covered under one or more of Miami University's Health, Dental and Vision plans. Use this form to verify the information provided or to make any changes if it applies to you.
3. **Miami University Affidavit of Same-Sex Domestic Partnership** – While you may have previously submitted this form to the University, you must submit a Miami University Same-Sex Domestic Partnership Affidavit again.

What You Need to Do Now:

1. **Read all of the** enclosed information. If you need help understanding any of these materials, contact *HCS* at **1-866-617-4271**
2. Collect the required documents.
3. Fax or Mail copies of the required documents directly to *HCS*.

Fax to: **1-888-849-1127** or

Mail to: *HCS*
 PO Box 42420
 Cincinnati, OH 45242

Your reply must be postmarked no later than **8/17/2009**

4. Keep copies of the documents you have sent to *HCS* for backup purposes. **DO NOT SEND ORIGINALS.** Please write your name and either Banner ID or Social Security Number on the back of all documents you submit.

Participation in this process is **mandatory**. To avoid losing coverage for your eligible dependents, be sure to return the required documentation in the enclosed pre-addressed envelope, postmarked no later than **8/17/2009**.

Dependent Verification Form for Eligibility Certification

Review the facts on this form to verify that the information it contains is accurate and complete. If you need to make changes or add missing information, please do so in the area provided.

This verification is required if you have dependent(s) enrolled in your Health, Dental and/or Vision plans. Be sure to:

- Review and sign this form
- Enclose the appropriate documentation found on the list of *Description of Eligible Dependents* (page 5). Please black out any information not pertinent to audit and write the employee's name and Banner ID or social security number on the back of all document copies
- Fax or mail to HCS as directed. **DO NOT SEND ORIGINALS.** They will not be returned.
- Be sure to keep a photocopy for your records.

Dependent Name	SS# *	Relationship	Date of Birth
Dependent 1	xxx-xx-1234	Spouse	MM/DD/YYYY
Dependent 2	xxx-xx-5678	Child	MM/DD/YYYY
Dependent 3	xxx-xx-9012	Child	MM/DD/YYYY

*I, **<insert employee name>**, hereby attest that the dependents listed above meet the criteria as described on the form entitled *Description of Eligible Dependents*.*

Employee Signature

Date

<insert employee name>

Fax to: 1-888-849-1127
or

Mail to: **HCS**
PO Box 42420
Cincinnati, OH 45242

Description of Eligible Dependents

Who is an Eligible Dependent under your Miami University Health, Dental, Vision Plans (the "Plan")?

Spouse

The Employee's spouse is recognized under the laws of the state where the Subscriber resides provided, however, that the spouse shall be of the opposite gender and that the spouse and the Subscriber share the same permanent residence.

Required Documentation

Signed Dependent Verification (enclosed)

AND

Photocopy of marriage certificate with appropriate signatures (certificates issued by religious institutions will not be accepted)

Resources to Obtain Documentation

www.marriagelicense.com

County office that issued original marriage certificate

Same Sex Domestic Partner

The Employee's Same-Sex Domestic Partner is recognized based on completion of the Miami University Affidavit of Same-Sex Domestic Partnership.

Required Documentation:

Signed Dependent Verification (enclosed)

Miami University Affidavit of Same-Sex Domestic Partnership (enclosed)

AND two of the following:

Joint ownership of a motor vehicle Car Registration

Joint checking account - Statement or Agreement document

Joint credit account - Statement or Agreement document

Joint ownership of a residence - Agreement Residential lease identifying both partners as tenants

Please note:

- No person can be covered both as an employee and as a dependent.
- No parents or grandparents, regardless of legal guardianship can be enrolled.

Your dependent children (as described below) are covered:

- to the end of the year in which the child attains age 19
 - to the end of the year in which the child attains age 24 if the child is documented as a full-time student enrolled in a state-accredited college, university, trade or secondary school on a full-time basis during calendar year 2009
 - if any age and became disabled and incapable of self-support before their coverage would have otherwise ended.
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Dependent Children

- Your unmarried, natural or legally adopted children, including children who have been placed with you for legal adoption.
- Your unmarried stepchildren who live with you or for whom your spouse is required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO).
- Any other children who are related to you by blood or marriage, who live with you in a regular parent-child relationship, and for whom you have obtained legal custody or guardianship.
- Children for whom you are required to provide medical coverage under a QMCSO.

Child by Birth ★★★★★★★★★★★★★★

Required Documentation:

Signed Dependent Verification (enclosed)

AND one of the following:

Photocopy of certified birth certificate, or

Photocopy of hospital verification of birth, or

Photocopy of immigration papers that identify parent-child relationship

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

www.birthcertificate.com

U.S. Department of State (for children born outside the United States)*

Hospital in which child was born

County office that issued original birth certificate

Social Security Administration

College Registrar

*U.S. Department of State

Passport Correspondence Branch, Overseas Birth

1111 19th Street NW Suite 510

Washington DC 20522-1705

(202) 955-0307

Child by Adoption ★★★★★★★★★★★★★★

Required Documentation:

Signed Dependent Verification (enclosed)

AND one of the following:

Photocopy of court-approved adoption, or

Photocopy of placement letter from court/adoption agency

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

State agency that issued final adoption papers

Adoption agency that issued placement papers

Social Security Administration

College Registrar

Child by Custody or Guardianship ★★★★★★★★★★★★★★

Required Documentation:

Signed Dependent Verification (enclosed)

AND:

Photocopy of certified court-ordered custody/guardianship

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

State agency that issued custody/guardianship papers

Social Security Administration

College Registrar

Stepchildren ★★★★★★★★★★★★★★

Required Documentation:

Signed Dependent Verification (enclosed)

AND

Photocopy of marriage certificate with appropriate signatures (certificates issued by religious institutions will not be accepted)

AND one of the following:

Photocopy of certified birth certificate, or

Photocopy of hospital verification of birth, or

Photocopy of immigration papers that identify parent-child relationship

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

www.marriagelicense.com

U.S. Department of State (for children born outside the United States)*

Hospital in which child was born

County office that issued original birth certificate

www.birthcertificate.com

County office that issued original marriage certificate

Social Security Administration

College Registrar

Same-Sex Domestic Partner's child by birth ★★★★★★★★★★★★★★

Required Documentation:

Birth Certificate

AND

Miami University Affidavit of Same-Sex Domestic Partnership (enclosed)

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

www.birthingcertificate.com

- U.S. Department of State (for children born outside the United States)*
- Hospital in which child was born
- County office that issued original birth certificate
- Social Security Administration
- College Registrar

*U.S. Department of State
 Passport Correspondence Branch, Overseas Birth
 1111 19th Street NW Suite 510
 Washington DC 20522-1705
 (202) 955-0307

Same-Sex Domestic Partner’s child by adoption ★★★★★★★★★★★★★★

Required Documentation:

- Court approved adoption order *or*
- Placement letter from court or adoption agency for pending adoptions

AND

Miami University Affidavit of Same-Sex Domestic Partnership (enclosed)

- *If dependent child is between the ages of 19 and 24, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

- County court that issued final adoption order
- County court or adoption agency that issued placement letter
- Social Security Administration
- College Registrar

Same-Sex Domestic Partner’s child by legal guardianship ★★★★★★★★★★★★★★

Required Documentation:

- Court or agency order establishing guardianship
- AND**
- Affidavit of Residence and/or Dependency for “Other” Children (enclosed)

AND

Miami University Affidavit of Same-Sex Domestic Partnership (enclosed)

- *If dependent child is between the ages of 19 and, you must also provide:* Photocopy of current full-time college schedule, or photocopy of current full-time college registration
- *If dependent child is disabled, you must also provide:* Photocopy of Social Security disability award

Resources to Obtain Documentation:

- County court that issued guardianship order
- Social Security Administration
- College Registrar



I, _____, hereby certify that _____ is my same-sex domestic partner and that:

1. We share a residence (unless residing in different cities, states, or countries on a temporary basis)
2. We are in a long-term committed relationship and have been in this relationship for at least six (6) months.
3. We are of the same sex as each other and we are each other's sole domestic partner and intend to remain so indefinitely.
4. We are at least eighteen (18) years of age or older.
5. We are not legally married to anyone.
6. We are not related by blood closer than would bar marriage in the State of Ohio.
7. We are mentally competent to consent to a contract.
8. We share financial obligations, as demonstrated by the existence of at least two of the following conditions (please check all that apply):

We have common or joint ownership of a residence (house, condo, or mobile home)

We share at least two (2) of the following:

- Joint ownership of a motor vehicle
- Joint checking account
- Joint credit account
- Residential lease identifying both partners as tenants

My partner has been designated as a primary beneficiary of at least one (1) of the following:

- My Miami University Group Term Life Insurance
- My will

NOTE: Documentation is required to prove the existence of the above-mentioned conditions.

I agree to file, within 30 days of the dissolution of my same-sex domestic partnership, an *Affidavit of Termination of Same-Sex Domestic Partnership* with the office of Benefit Services affirming that the partnership has been terminated and that a copy of the *Affidavit of Termination of Same-Sex Domestic Partner Status* has been mailed to my previous partner.

I understand that another *Affidavit of Same-Sex Domestic Partnership* cannot be filed until six (6) months after the most recent partnership has been terminated. I also understand that an *Affidavit of Termination of Same-Sex Domestic Partner Status* must be filed with the office of Benefit Services and also mailed to the previous partner.

I understand the information on this affidavit will be used by the University for the sole purpose of determining my eligibility for same-sex domestic partnership benefits. This information will be treated as confidential to the extent permitted by Ohio law and will be used solely for the administration of benefits by the office of Benefit Services. I understand that availability of these benefits is based on eligibility requirements and subject to changes in program provisions.

Signature of Employee: _____ Date: _____

Printed Employee: _____

AFFIDAVIT

Being duly sworn, I, the undersigned individual, state that all responses made in this Affidavit of Same-Sex Domestic Partnership Form are true and accurate to the best of my knowledge and belief.

Employee Signature: _____

Sworn to and subscribed in my presence this _____ day of _____, 20____

Notary Public _____ State of Ohio,

County of _____

My Commission Expires: _____