Sandoval County Dependent Eligibility Certification Form

In accordance with City of Albuquerque Entity Administrative Guide, dependents must meet specific eligibility requirements to be covered under the City of Albuquerque group plan. Eligible dependents include:

- Employee spouse – a person to whom you are legally married. The term "spouse" does not include common law marriage
- Domestic partners or other partners of relationships not defined as marriage under the law of the state or foreign county in which they were entered. (Affidavit of Domestic partner required)
- Natural child – your biological child, spouse's biological child or domestic partner. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Child with a disability– employee, spouse or domestic partners covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26 if you provide adequate documentation validating disability
- Legal guardianship – a child (your ward, spouse or domestic partner) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Legally Adopted child – employee, spouse or domestic partners legally adopted child pursuant to a Judgment of Adoption; or a child placed in your home for the purpose of adoption in accordance with applicable state and federal laws.
- **Extended Family members such as parents and other dependent relatives, e.g. aunts, uncles, and cousins are not eligible under any circumstances.**

Based on the definitions above, please list all eligible dependents below that are currently covered under ANY state insurance plan or those you want to add to a plan(s). If you do NOT list a covered dependent, the dependent will be removed from coverage

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATION

Employee signature: ________________________________ Date: ______________________

RETURN TO HUMAN RESOURCES

TO BE COMPLETED BY HUMAN RESOURCES:

Date Received in HR: ______________________Date:____________________________

HR Rep/Date. ______________________________