60983

GRANDCHILD ELIGIBILITY VERIFICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 60983 (Rev. 02-2022)

Clear Form

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PART A MEMBER INFORMATION

Employee Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Employee Date of Birth (mm/dd/yyyy)
Adult Dependent Name (Parent of Grandchild)	Adult Dep. Date of Birth (mm/dd/yyyy)
Grandchild Name	Grandchild Date of Birth (mm/dd/yyyy)

PART B MEMBER VERIFICATION

By submitting this form, **along with a copy of my grandchild's birth certificate**, I certify that my grandchild named above is eligible for coverage under the Plan because the below criteria are met (check all applicable criteria):

☐ The parent of the grandchild is covered under the Plan and under age 22; and physically resides with me; and is chiefly dependent upon me for support.

☐ The parent of the grandchild is covered under the Plan and under age 26; and is a full-time student; and is chiefly dependent upon me for support.

Enter name of college/school where your adult dependent is a full-time student			
Address of College/School	City	State	ZIP Code

☐ The parent of the grandchild was claimed as a financial dependent on my federal income tax return in the previous tax year and I will continue to claim this child on my federal income tax return for every year that I continue enrollment for the child.

By signing this form, I agree that I will provide any and all supporting documentation necessary to verify the above certifications. I understand that by signing this form, I am agreeing to notify NDPERS in writing within 31 days after the above-named child is no longer eligible for coverage as a dependent grandchild, including my failure to declare this individual on my federal tax return as dependent or if any individual other than myself represents this child as their dependent for federal income tax purposes. I understand that the furnishing of false information or the failure to notify NDPERS of any changes in dependency status may result in the denial of coverage, repayment of any benefits paid during any period where the individual was not eligible for dependent grandchild coverage and, as applicable, referral for disciplinary sanctions. I further understand that the Plan reserves the right to require grandchild dependency eligibility re-certification annually or to audit the continued eligibility of plan participant at any time without prior notice.

I certify that the answers I have provided on this verification form are true and correct to the best of my knowledge and belief and no information required to be given either expressly or by implication has been knowingly withheld. I understand that a misrepresentation of material facts made by an applicant for health insurance coverage may be used to void this policy and deny claims to any person covered under this Policy.

Member's Signature (Electronic signatures will not be accepted)	Date of Signature