(DEVA Verification Letter)

NEW YORK STATE | **NYSHIP** New York State Health Insurance Program

Dependent Verification
PO Box 165308
IRVING, TX 75016-9923

hms Employer Solutions

PC or Mobile Upload: www.VerifyOS.com

FAX: 1-877-223-8478

Go green at www.VerifyOS.com!

Date, 2016

Emp_Name
Street
Street2
City, St, Zip

EID bar code

REFERENCE NUMBER: EID

RESPOND BY: DATE, 2016

Dear Emp_Name,

The New York State Health Insurance Program (NYSHIP) has contracted with *the independent firm*, HMS Employer Solutions (HMS), to verify that dependents enrolled in NYSHIP meet the Program's eligibility requirements. In order for your dependent(s) to continue to receive benefits under NYSHIP, **your action is required. You must submit proof of their eligibility to HMS so that it is received by DATE, 2016.**

As a reminder, eligible dependents are defined in the NYSHIP General Information Book as:

- Your spouse, including a legally separated spouse. *Note: If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.
- Your domestic partner if you are both 18 years or older; have been in the partnership for at least six months; are both unmarried; are not related in a way that would bar marriage; have shared the same residence and have been financially interdependent for at least six months; and have an exclusive mutual commitment (which you expect to last indefinitely) to share responsibility for each other's welfare and financial obligations.
- Your child up to age 26. Coverage may be extended past the age of 26 if the child is incapable of self-support by reason of mental or physical disability; is unmarried; and was incapacitated before the age at which dependent coverage would otherwise be terminated.
- Coverage may also be extended past the age of 26 for an unmarried child who is a full-time student, had four years of service in a branch of the U.S. Military between the ages of 19 and 25 and is not eligible for other employer group coverage. Up to four (4) years of military service may be deducted from the child's age until the adjusted eligibility age equals 26.

A child is defined as your natural child; stepchild; child of your domestic partner; legally adopted child, including a child in a waiting period prior to finalization of adoption; or your "other" child. An "other" child must be chiefly dependent upon you; reside with you; and be a child for whom you have assumed legal responsibility in place of the parent. The "other" child must have met the above requirements before age 19.

A detailed list of documents required to prove eligibility of your dependent(s) can be found on the reverse side of this letter. Copies of the documents and the enclosed Verification Form must be received by HMS by **DATE, 2016**.

If after reading the attached Frequently Asked Questions (FAQ) you still have questions, please feel free to call HMS at (XXX) XXX-XXXX from 8am to 11pm Eastern Time, Monday through Friday. Thank you for your cooperation with this important effort to control health care plan costs.

¿Español?

Para asistencia en español, por favor comuníquese con HMS Employer Solutions al 888-888-8888.

(over) →

EID bar code

REQUIRED DOCUMENTS

All required documents MUST contain the date (including year), enrollee name, and dependent's name. Personal information such as Social Security Numbers, account numbers, and financial information should be marked out for confidentiality.

FOR SPOUSE:

- A copy of your marriage certificate
- **AND one of the following:**
  - A copy of the front page of your most recently filed 2014 or 2015 federal tax return (form 1040) confirming this dependent is your spouse
  - A document dated within the last 60 days showing current joint financial responsibility such as a recurring monthly household bill or statement of account. The document must list your spouse's name, the date and your mailing address. Note: Health care bills will not be accepted as proof of eligibility as health care coverage is being verified.

FOR DOMESTIC PARTNER:

- A copy of the Affidavit of Domestic Partnership PS-425.1 (*available on www.VerifyOS.com)*
- **AND** copies of two (2) proofs of joint responsibility for basic financial obligations dated within the last six (6) months. See PS-425.1 for acceptable proofs required from lists A and B.
- **AND** a copy of one (1) proof of cohabitation dated within the last six (6) months. **The proof must specify the residential address. A PO Box or other *mailing only* address will not be accepted.** See PS-425.1 for acceptable proofs.

FOR CHILDREN UP TO AGE 26 AND DISABLED CHILDREN:

- A copy of the child's birth certificate, hospital birth record, or adoption certificate naming you or your spouse as the child's parent

FOR "OTHER" CHILDREN:

- A copy of the Statement of Dependence PS-457 form (*available on www.VerifyOS.com)* **AND**
- A copy of your 2014 or 2015 1040 claiming this child as a dependent **OR** if you do not claim the dependent, a letter from a CPA or an attorney stating that the dependent could be claimed on your tax return under current IRS regulations if you chose to do so.
- A document showing current residency such as a statement of account (such as a bank statement or investment statement) or school or daycare paperwork. The document must list the child's name, a date within 6 months and your mailing address.

FOR MILITARY DEPENDENTS:

- A copy of the child's birth certificate, hospital birth record, or adoption certificate naming you or your spouse as the child's parent **AND**
- A copy of the schedule indicating full-time status in an accredited educational institution. Please note: The schedule must list the student's name, the name of the institution, a 2016 term and indicate full-time status.

Note for Stepchild: If you are covering a stepchild, you must also provide documentation of your current relationship to the child's parent as requested above.

Verification Form

Return this form with the required documentation

EID bar code

Name: Emp_name

PC or Mobile Upload: www.VerifyOS.com

Reference Number: EID

FAX: 1-877-223-8478

According to our records, the following dependent(s) require verification at this time:

Enrolled Dependent Name | Relationship	Does this person meet the definition of an eligible dependent?		If not eligible, please indicate the date of ineligibility.
	YES	NO	
dep_1	☐	☐	
dep_2	☐	☐	
dep_3	☐	☐	

For dependents that do not meet the definition of an eligible dependent, no documentation is required and the ineligible dependent **will be removed from all health care coverage retroactively to January 1, 2016.**
** Please note that due to federal regulations, dependents covered under a NYSHIP Medicare plan will be removed from coverage on a prospective basis by the Department of Civil Service as soon as administratively possible. **

To complete the verification process for eligible dependents, simply follow these steps:

- Collect copies of all **required documents** (listed on page 2) for each enrolled dependent.
- **Sign** and **date** the signature box below.
- Submit **this form** together with **copies** of all **required documents** to HMS Employer Solutions so they are received by DATE, 2016. Please ensure a copy of this form is included with all documents submitted.
- For faster processing, please submit required documents by uploading them via the web portal, www.VerifyOS.com, or by faxing them to 1-877-223-8478. If the web and fax are unavailable to you, documents may be mailed to HMS Employer Solutions, P.O. Box 165308, Irving, TX 75016-9923. **Please do not mail original documents.**

By my signature on this form, I certify to NYSHIP that (1) all information on this form is true, correct, and current as of the date signed and (2) all "**REQUIRED DOCUMENTS"** that are submitted are authentic. I understand any attempt to maintain coverage for an ineligible dependent will be subject to appropriate disciplinary action.

Signature of Enrollee: _____ **Date:** _____