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55 Water Street, New York, New York 10041-8190

Health Benefit Dependent Audit
Response Requested – Please Do Not Discard

«Date»

«First_Name» «Last_Name»
«Street»
«Apt/Unit»
«City», «State» «Zip»

Dear «First_Name» «Last_Name»:

With health care costs rising, it is critically important that the premiums our members pay and the monies we spend on benefits are for those who are eligible to receive them, as defined by your EmblemHealth benefits plan.

We ask for your assistance as we conduct an audit in partnership with HR Best Practices to confirm the eligibility of dependents currently insured under your coverage. Your dependents can include a spouse, domestic partner and/or children. As the contract holder, you are requested to provide documentation of your enrolled dependents. Please complete the following steps no later than «**MM/DD**»:

1. Complete and sign the enclosed Dependent Confirmation Form to continue benefits or remove ineligible dependents.
2. Collect **unaltered** copies of "official" documents that support proof of dependency for **each** listed dependent.
3. Complete the enclosed Proof Checklist Form.
4. Mail all of the above by «**MM/DD/YR**» to the following address:

HR Best Practices
c/o EmblemHealth Dependent Audit
601 Hamburg Turnpike - Suite 303
Wayne, NJ 07470

You may also send the above information by secure fax to **1-877-687-8712** or e-mail to **DepAudit@HRBestPractices.com**

It is important that you send the documents needed in order to avoid interruption of health care benefits for your dependent(s).

If you have questions about this letter, please call HR Best Practices at **1-973-942-6789** or visit **www.HRBestPractices.com**. Please be advised that EmblemHealth will **not** accept calls regarding the audit. All calls will be referred to HR Best Practices.

Thank you for your understanding and cooperation.

Sincerely,

Marilyn DeQuatro
Senior Vice President
Customer Service Division

Enclosures (3)

DEPENDENT CONFIRMATION FORM

(To be used to continue benefits for eligible dependents or to remove a member from the benefit plan)

Contract Holder Acknowledgement

I have identified dependents that meet the eligibility criteria for the EmblemHealth benefit plan and have attached the required supporting documentation and/or I have identified dependents that need to be removed from the EmblemHealth medical plan.

Dependent Name	Date of Birth	Social Security Number (last 4 digits)	Relationship	Confirm *(Write "Yes" to confirm or "No" to remove)*
Example: Sue Smith	01/01/1970	xxx-xx-1234	Spouse	Yes
Dependent name 1	DOB1			
Dependent name 2	DOB2			
Dependent name 3	DOB3			
Dependent name 4	DOB4			
Dependent name 5	DOB5			

I confirm the above dependent information and the enclosed supporting documentation is true and may be used to validate enrollment of these dependents in the EmblemHealth benefit plans.

_____ _____

Contract Holder Name Contract Holder ID

_____ _____

Contract Holder Signature Date

This form (E-1) must be submitted to HR Best Practices before MM/DD/YY.
PLEASE BE SURE TO INCLUDE THE REQUIRED DOCUMENTATION

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PROOF CHECKLIST FORM

Member Information:
Contract holder Name (please print): _____ Zip Code _____

Telephone Number _____ Best Time to Call: ☐ AM ☐ PM ☐ Late PM

Total Number of Proof Documents _____

Total Number of Dependents _____ (as printed on Dependent Confirmation Form)

Questions:
In accordance with the IRS spouse guidelines, please answer the following "yes" or "no" questions:

1. I have lived with my spouse for the past six months. ☐ Yes ☐ No
2. I provide at least 50 percent of the financial support to keep up our home. ☐ Yes ☐ No
3. My spouse and I filed our taxes as a married couple in 2009. ☐ Yes ☐ No
4. I have obtained a final decree of divorce or separate maintenance agreement. ☐ Yes ☐ No

Dependent proof included (Please check only those forms that have been included):

Spouse:

- ☐ Marriage certificate
- ☐ Driver's license (front)
- ☐ 2009 Federal Tax Return (1040 – top half only)

Same Gender Domestic Partner or Civil Union:

- ☐ Domestic Partner Registration Form
- ☐ DCFIF 9refer to enclosed Reference Guide)
- ☐ Copy of civil union or registration documentation

Children:

- ☐ Birth certificate
- ☐ Adoption papers/Legal guardian papers
- ☐ College/university registration document or transcript
- ☐ Physician's statement of disability

Other:

- ☐ Copy of Qualified Medical Child Support Order and birth certificate
- ☐ Copy of court order

DEPENDENT ELIGIBILITY REFERENCE GUIDE AND REQUESTED PROOF DOCUMENTATION

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUESTED
CURRENT SPOUSE	A person to whom you are legally married.	Any ONE of the following: ➢ A copy of the certified Marriage Certificate (state/county issued) ***and*** a copy (front) of the spouse's driver's license. ➢ A copy of the top half of the front page of your 2009 federal tax return (Form 1040) that includes the spouse (can black out dollar amounts). ➢ Place of worship marriage certificate ***and*** a copy (front) of the spouse's driver's license.
FORMER SPOUSE	A person to whom you were once legally married and continued coverage is specified under a legal agreement until the spouse remarries.	➢ A copy of the divorce agreement showing that you are required to provide medical coverage to your ex-spouse.
SAME GENDER DOMESTIC PARTNER	A person of the same gender with whom you have entered into a domestic partnership (in states where marriage is not allowed). In states where a civil union, registration or marriage is recognized, you must comply with this to qualify as benefit eligible.	➢ A notarized copy of the Domestic Partner Registration Form **AND** ➢ A notarized copy of the EmblemHealth Declaration of Cohabitation & Financial Interdependence Form (DCFIF) as well as the 3 forms of proof cited in the DCFIF.
CHILDREN	Unmarried children under age 26 **ONLY IF** other insurance is not available through his/her employer or Medicare). Covered if they are you or your spouse's or partner's: -Natural Children -Step Children -Legally adopted children, or those placed in your home for whom you have begun adoption procedures -Children living with you for whom you are appointed Legal Guardian by the court and for whom you are financially responsible. -Disabled children over 25.	➢ A copy of the top half of the front page of your 2009 federal tax return (Form 1040) that includes the dependent (can black out dollar amounts). **AND** ➢ **Natural Child** – A copy of the child's birth certificate showing you as a parent ➢ **Step Child** – A copy of the child's birth certificate. ➢ **Adopted Children/Legal Guardianship** – A copy of the Final Court Orders **or** Adoption Final Decree each with the presiding judge's signature and seal. ➢ **AND if Disabled Child over age 25 –** copy of physician's statement
OTHER DEPENDENTS	An alternate recipient under age 26 who is covered under a qualified child support order (QMCSO) or other dependents if required under a court order.	➢A copy of the QMCSO or court order **AND if QMCSO** – copy of the child's birth certificate.