UCI Graduate Division

120 Aldrich Hall
Irvine, CA 92697-3180
Phone: (949) 824-4611
www.grad.uci.edu

Child Dependent Health Insurance Attestation Form

If you are an Academic Student Employee (ASE) or Graduate Student Researcher (GSR) represented by the United Auto Workers (UAW), use this form to request remission/ reimbursement for your child dependent's health insurance premium pursuant to the Health Benefits article of the ASE (Article 14) and GSR (Article 13) collective bargaining agreements, UCSHIP regulations, and the procedures established at your location.

Once completed, please return the completed Form and any other required documents to your department administrator or designated campus office. Check your location's procedures additional information on timeline for submission and any additional verification requirements.

Only one Form is needed per quarter/semester, however, you will need to submit a new Form for each quarter/semester in which you are requesting remission/reimbursement.

Employee Information

First and Last Name:

Employee ID:

Email Address:

Appointment Information - Please complete all fields below for each applicable appointment during the quarter/semester in which you are enrolling a qualifying dependent.

Appointment 1:

Quarter/Semester: Fall

Job Title: -

Percentage FTE:

Begin Date of Appointment:

End Date of Appointment:

Department:

Appointment 2 (if applicable):

Quarter/Semester: Fall

Job Title: -

Percentage FTE:

Begin Date of Appointment:

End Date of Appointment:

Department:

UCI Graduate Division

120 Aldrich Hall
Irvine, CA 92697-3180
Phone: (949) 824-4611
www.grad.uci.edu

Attestation of Eligibility

Please select all of the following that apply for you during the quarter/semester in which you are enrolling child dependents in UCSHIP.

☐ I am an Academic Student Employee (ASE) and/or a Graduate Student Researcher (GSR) who is eligible to receive a health insurance premium remission as defined under the ASE and/or GSR collective bargaining agreements.

☐ I have a child dependent(s), as defined by UCSHIP plan regulations. Regulations are outlined at https://myucship.org/.

☐ I will provide a receipt of the payment for enrollment for my child dependent(s) in UCSHIP to my department administrator or designated campus office within ten (10) days of enrollment or as specified in local procedures.

☐ My income exceeds the Medi-Cal eligibility threshold for my family size. Information about Medi-Cal eligibility can be found here: https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx

If you have a spouse, please check the following section:

☐ I have a spouse and the combination of our income does not place our family over the Medi-Cal eligibility threshold for our family size. Information about Medi-Cal eligibility can be found here: https://www.dhcs.ca.gov/services/medi- cal/Pages/DoYouQualifyForMedi-Cal.aspx

☐ I certify that the information provided above is a true and accurate reflection of my eligibility status for the quarter/semester in which I am seeking a child dependent insurance premium payment.

☐ I have completed and executed this form to the best of my knowledge and I have carefully reviewed UCSHIP plan regulations to verify the eligibility of the child dependent(s) and the Medi-Cal eligibility thresholds from the California Department of Health Care Services to verify my eligibility.

☐ I understand that if I do not enroll a dependent on the UCSHIP plan after submitting this Form, or if I try to enroll but am not eligible for enrollment in UCSHIP, and a dependent premium remission/reimbursement payment has been made to me, I shall reimburse the University for the remission/reimbursement payment.

☐ I understand that falsifying information on this Form regarding my eligibility for the dependent remission/reimbursement may be subject to discipline, up to and including dismissal.

First and Last Name: Date:

Signature: