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 reimbursement for your child dependent's health insurance premium pursuant to Article __ – Health Benefits of the ASE/GSR collective bargaining agreement, UC SHIP regulations, and the procedures established at UCI.

Once completed, please return the completed Form and any other required documents to your department administrator. Additional information on timeline for submission and any additional verification requirements can be found at https://grad.uci.edu/wp-content/uploads/2024/08/BXBR-Child-Dependent-Health-Premium-Benefit-Program-Overview-and-Procedures-for-Departments.pdf

Only one Form is needed per quarter, however, you will need to submit a new Form for each quarter in which you are requesting 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 in which you are enrolling a qualifying dependent.

Appointment 1:

Quarter:

Job Title:

Percentage FTE:

Begin Date of Appointment:

End Date of Appointment:

Department:

Appointment 2 (if applicable):

Quarter:

Job Title:

Percentage FTE:

Begin Date of Appointment:

End Date of Appointment:

Department:

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Attestation of Eligibility

Please select all of the following that apply for you during the quarter in which you are enrolling child dependents in UC SHIP.

- ☐ I am an Academic Student Employee (ASE) and/or a Graduate Student Researcher (GSR) who is eligible to receive a health insurance premium reimbursement as defined under the ASE/GSR collective bargaining agreement.
- ☐ I have a child dependent(s), as defined by UC SHIP 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 UC SHIP to my department administrator or designated campus office within ten (10) days of enrollment.
- ☐ 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/Medi-Cal/Pages/qualify.aspx
  If you have a spouse, please check the following section:
  - ☐ I have a spouse and the combination of our income does not exceed twice the designated Medi-Cal eligibility threshold. Information about Medi-Cal eligibility can be found here: https://www.dhcs.ca.gov/Medi-Cal/Pages/qualify.aspx
- ☐ I certify that the information provided above is a true and accurate reflection of my eligibility status for the quarter 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 UC SHIP 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 UC SHIP plan after submitting this Form, or if I try to enroll but am not eligible for enrollment in UC SHIP, and a dependent premium reimbursement payment has been made to me, I shall reimburse the University for the reimbursement payment.
- ☐ I understand that falsifying information on this Form regarding my eligibility for the dependent reimbursement may be subject to discipline, up to and including dismissal.

First and Last Name: Date:

Signature: