LEGALLY DOMICILED ADULT CERTIFICATION FORM

Employee Information

Name: ______________________________ Social Security Number: ______________

Address: ____

Legally Domiciled Adult Information

Name: ____

Date of Birth: ____________________ Social Security Number: ____________________

Affirmation of Legally Domiciled Adult Eligibility

The individual for whom I am applying for coverage satisfies the following requirements:

	Yes	No
1. Is at least 18 years of age.	☐	☐
2. Shares basic living expenses and are financially interdependent with the employee.	☐	☐
3. We reside together in the same residence and intend to do so indefinitely.	☐	☐
4. We have resided in the same residence for at least six months.	☐	☐
5. We are not sharing the same domicile solely for the purpose of obtaining benefits coverage.	☐	☐
6. We are jointly responsible for each other's common welfare and share financial obligations.	☐	☐
7. If requested, we can provide at least two of the following:	☐	☐

- Driver's license listing a common address.
- Tax returns listing a common address.
- Bank, credit card or other financial or utility statements listing a common address.

CHANGE IN STATUS

We agree to notify the Michigan Catholic Conference within 30 days of any change in status which would make the Legally Domiciled Adult no longer eligible for benefits by filing a Certification of Termination of Legally Domiciled Status.

The Certification of Termination shall affirm that the Legally Domiciled Adult coverage is terminated as of the date of the execution specified therein and that a copy has been mailed to the other party by the party authorizing the action.

ACKNOWLEDGMENTS

1. We have provided the information in this Certification Form for the sole purpose of determining our eligibility for Legally Domiciled Adult benefits.
2. We understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the Employee to disciplinary action.
3. We understand that the Michigan Catholic Conference may change benefit coverage and eligibility at any time.
4. We understand that information provided in this Certification Form will be held confidentially, but will be subject to disclosure (a) upon the express written authorization of the Employee; (b) upon request of the insurer or plan administrator; or (c) if otherwise required by law.
5. We affirm, under penalty of perjury, that the statements in this Certification Form are true and correct.
6. We agree that in the event of a false declaration or the failure to file a Certification of Termination with the Michigan Catholic Conference, the Michigan Catholic Conference may recover damages from the Employee for all costs and expenses incurred by the Michigan Catholic Conference as a result of the false certification, including, but not limited to, attorneys' fees incurred by the Michigan Catholic Conference to recover such damages.
7. Michigan Catholic Conference has advised us to consult with an attorney regarding the legal consequences of signing this Certification Form.
8. We understand that we will need to provide a Legally Domiciled Adult Tax Treatment Certification Form to my Employer.

____________________________________ ________________
Employee Signature Date

____________________________________ ________________
Legally Domiciled Adult Signature Date

FOR MCC USE ONLY

Declaration received and approved by: ________________________ ________________
Date