Mountain View Whisman School District

BENEFIT ELIGIBILITY AUDIT FORM

PLEASE PRINT – GREY SECTIONS WILL BE FILLED OUT BY DISTRICT CERTIFYING OFFICIAL ONLY

Employee Name: _____
as it appears on your social security card

Home Address: _____

Mailing Address: _____

Home Phone #: _____ Message Phone #: _____

Last 4 Digits of SS#: _____ Date of Birth: _____

Job Title: _____ Work Site: _____

INSURANCE PLANS

☐ Kaiser ☐ United Health Care ☐ Delta Dental ☐ VSP

Spouse, Domestic Partner, Children – See Eligibility Criteria

Name	List Exact Relationship (Spouse, Domestic Partner, Birth Child, Step Child, Legal Guardian, etc.)	Date of Birth	*Plans Enrolled	BC	MC/ DP	CD	FTS	IRS	DROP

*Plans Enrolled Legend:
K = Kaiser; UHC = United HC; DD=Delta Dental; VSP

BC = Birth Certificate
MC = Marriage Certificate
DP = Domestic Partner Certificate
CD = Court Document

FTS = Full Time Student
DROP = Drop Dependent
IRS = Tax Returns 2018

EMPLOYEE CERTIFICATION

Under penalty of perjury, my signature certifies the dependents listed above are eligible under the District's Dependent Eligibility Criteria. I understand that if required documents have not been provided, my non-verified dependents' coverage will be terminated.

_____ _____
Employee Signature (To be signed in the presence of Certifying Official) Date

Mountain View Whisman Verification Audit Complete ☐ Yes ☐ No Follow-Up Required ☐ Yes ☐ No

Certified by: _____ Date Certified: _____
Name of Staff Person Certifying Document