TOWN OF GLASTONBURY

SUPPORTIVE DOCUMENTATION LISTING
FOR MEDICAL AND/OR DENTAL ENROLLMENT

SELF (Employee Only)

- No documentation required.

SPOUSE:

- If married within the last year, a copy of your Marriage Certificate, or if married longer than one year:
    - Evidence of joint responsibilities in common household expenses (copy of a recent utility or telephone bill dated within previous 6 months, addressed to your home address which clearly indicates both your name and your spouse's name on it, or
    - Current proof of Automobile Insurance if both names and current address are indicated, or
    - Ownership of a joint credit card statement, dated within previous 6 months, addressed to your home address which clearly indicates both your name and your spouse's name on it. The following information will need to be blacked out: transactions, credit limit, payment amount, and account number.

CHILD OR DEPENDENT:
Copy of child's Birth Certificate indicating parent's identity must be the full size version- not the small wallet size version.

- If covering your adoptive child, copy of adoption papers.
- If legal guardian to unmarried dependent child, copy of Probate Court documentation.
- If the dependent child resides with you, please be prepared to provide documentation, such as a copy of a current official school record that lists your address. Other proof should be current and list the same address you provide as your residence.
- If covering unmarried dependent children who do not live with you, a copy of the State of Connecticut Support Enforcement Documentation or other acceptable proof that children are your dependents or that you are the responsible party.

Proof of Student Status may be requested by the insurance carrier annually.

I do hereby swear, under penalty of false statement, that the documentation that I have provided to enroll my dependents into the Town's Medical and/or Dental Benefits are true.

I understand that if there are misrepresentations, these misrepresentations will effect the eligibility of Medical and/or Dental benefits for those dependents who are misrepresented and there is the possibility of these dependents not being eligible for medical/dental coverage and/or denial of benefits.

Employee

Print Name: _____

Signature: _____ Date: _____

Human Resources Representative

Signature: _____ Date: _____