University of Idaho
A LEGACY OF LEADING

Affidavit of Termination of Qualification of Other Eligible Adult

I,_____, declare the following:
(Print Employee's Name)

1. I cease to meet at least two of the criteria needed to maintain an Other Eligible Adult on my employee benefits plan.

_____.
(Print Name of Former Other Eligible Adult)

2. The effective date of the termination of qualifications is
_____.
(Date Qualification Ended)

3. I am filing this Affidavit of Termination of Qualification in order to notify the company that the above-named former Other Eligible Adult no longer satisfies the requirements to be recognized as an Other Eligible Adult.

I understand that the effect of filing this Affidavit of Termination of Qualification of Other Eligible Adult is that the Other Eligible Adult (and any of his or her children, if applicable) will no longer be covered under the plan as of the date of this termination of qualification. Coverage, therefore, will be terminated retroactive to that date, subject to federal and state regulation.

ACKNOWLEDGEMENT

I have provided the information in this Affidavit for use by the University for the purpose of determining eligibility for and participation in health care plans. I hereby affirm, under penalty of perjury, that the information in this Affidavit is true and complete to the best of my knowledge.

_____ _____
(Print Employee's Name) *(Date)*

_____ _____
(Signature) *(Vandal #)*

Please return your completed form to:
University of Idaho Benefits Center
P.O. Box 25408
Pittsburgh, PA 15220
Fax: (412) 922-6619