Legally Domiciled Adult Affidavit

The Legally Domiciled Adult of an associate may be eligible for participation in the SCL Health medical, dental, vision and/or supplemental life plans (LDA A only). For this purpose, an associate's LDA is an individual over 18 who shares the same principal residence as the associate, remains a member of the associate's household throughout the coverage period, and who falls within one of the following categories:

Category (A) Legally Domiciled Adult (LDA A) – (1) has lived with the associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially interdependent with the associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the associate by blood in any way that would prohibit marriage.

Category (B) Legally Domiciled Adult (LDA B) – (1) is the associate's adult relative (i.e., the child, sibling or parent of the associate by blood, adoption, or marriage), (2) the associate claimed the individual as a dependent on his or her federal income tax return for the preceding year, (3) has lived with the associate continuously for at least 6 months, and (4) for purposes of electing medical plan coverage, is not eligible for other coverage under another employer's group health plan or under Medicare ((unless the individual has Medicare based on disability).

Part I. Associate and Legally Domiciled Adult (LDA) General Information

Please note that both you and your LDA dependent must certify the accuracy of the information submitted on this form by signing Part IV.

Associate

Name:	Associate S-ID:
Work Site:	Phone Number:

LDA Candidate

Name:	Date of Birth:
Gender:	SSN:

Verification of Shared Principle Residence:

Date Associate and LDA entered into continuous shared principle residence: _____

Current shared residence address:
Length of time at this address:
Previous shared residence(s) if at current residence less than 12 months:

Part II. Eligibility Affirmation (choose either Category (A) or Category (B) below and complete only one)

By electing LDA coverage, I certify that all of the following eligibility criteria have been met.

Category (A) Legally Domiciled Adult **Please Check**

LDA Candidate is at least eighteen (18) years of age.	☐Yes ☐No
LDA Candidate has an ongoing, committed, and exclusive relationship with the associate.	☐Yes ☐No
LDA Candidate has lived with the associate for at least twelve months, and intends to do so during the entire coverage period.	☐Yes ☐No
LDA Candidate shares basic living expenses and is financially interdependent with the associate.	☐Yes ☐No
Neither LDA Candidate nor Associate has been in a civil union with, legally married to, or legally separated from, anyone else.	☐Yes ☐No
LDA Candidate is not legally related to the associate by blood in any way that would prohibit marriage in the state of his or her residence.	☐Yes ☐No

Category (B) Legally Domiciled Adult

LDA Candidate is at least eighteen (18) years of age.	☐Yes ☐No
LDA Candidate is the associate's child, sibling or parent by birth, adoption or marriage (step/in-law).	☐Yes ☐No
LDA Candidate has lived with the associate for at least six months and intends to do so during the entire coverage period.	☐Yes ☐No
The associate claimed the LDA Candidate as a dependent on his or her federal income tax return for the prior year.	☐Yes ☐No
If the LDA Candidate will be enrolled in SCL Health medical coverage, the LDA Candidate is not enrolled in or eligible for coverage another employer's group health plan or Medicare ((unless the individual has Medicare based on disability).	☐Yes ☐No

NOTE: If your LDA does not meet <u>all</u> of the criteria for either Category (A) or Category (B), s/he will not be eligible for Legally Domiciled Adult coverage under the SCL Health benefit plans.

Part III. LDA Election and Tax Treatment

Qualified LDA coverage is elected as marked below and according to the criteria outlined on Part II of this form.

Please Check One:

☐ **I request to enroll in coverage my LDA as a Category (A) Legally Domiciled Adult and, if applicable, his or her eligible dependent children. I certify that my LDA meets the criteria for a Category (A) LDA outlined in Part II of this form.**

Note: Category (A) LDA dependents (and their eligible dependent children) who do not qualify as the associate's federal tax dependents do not qualify for pre-tax deductions. Therefore, deductions for Category (A) LDA coverage will be taken on a post-tax basis. In addition SCL Health is required to tax the associate on the amount the company pays in premiums for the Category (A) LDA (and his or her eligible dependent children) to be on the associate's coverage. We suggest you discuss the tax implications of covering your LDA with your tax consultant. We also suggest you discuss the legal implications of covering your LDA with an attorney before enrolling in this coverage.

Does this LDA and, if applicable, his or her eligible dependent children, also meet the definition of your dependent under section 152 of the Internal Revenue Code for federal income tax purposes? ☐ Yes ☐ No

☐ **I request to enroll in coverage my LDA as a Category (B) Legally Domiciled Adult. I certify that my LDA meets the criteria for Category (B) LDA outlined in Part II of this form. I understand by enrolling an LDA under my coverage that I will not be allowed to also cover my legal spouse.**

Note: Category (B) LDA dependents are federal tax dependents of the associate and thus the deductions for this coverage will be made on a pre-tax basis. In addition, SCL Health is not required to tax the associate for the amount the company pays in premiums for the Category (B) LDA to be on the associate's coverage. We suggest you discuss the legal implications of covering your LDA with an attorney before enrolling in this coverage.

Part IV. Acknowledgment

- We acknowledge that we will be contacted by Cotiviti, SCL Health's third party dependent verification administrator, to re-verify this eligibility every plan year.
- We understand that if any of the information provided in this Affidavit is found to be false or if we provide any false supporting documentation to Cotiviti, SCL Health reserves the right to rescind coverage retroactively and/or to take disciplinary action and civil action, including termination of employment and recovery of benefits paid, legal fees, and taxes.
- We acknowledge that once the LDA is approved and eligibility verified, the associate may need to pay back premiums to original date of coverage for their LDA.
- We have been advised that we should consult with an attorney and tax consultant for advice regarding potential legal and or tax implications of electing coverage for an LDA.
- We agree to notify SCL Health of any changes to our relationship which would result in a loss of LDA eligibility as defined in Part II. We understand that failure to notify SCL Health could result in disciplinary action and recovery of benefits paid.
- We certify that the information provided in this Affidavit and any documentation provided in support of this Affidavit is true, complete, and accurate to the best of our knowledge.

Print Associate Name	Associate Signature	Date
Print LDA's Name	Legally Domiciled Adult Signature	Date

Notary Information:

Subscribed and sworn to before me this _____ day of _____, 20___ by _____.

Notary's official signature

_____

My commission expires:

_____ 20___

_____ County _____ State

Notary Seal

Submit this completed, notarized Affidavit to Cotiviti. Documents may be submitted via Upload on www.auditos.com website or Faxed to 1-877-223-8478 (toll-free).