

Star Tribune

Adult Child Eligibility Certification

Instructions: Employees must complete and return or fax this form to the Star Tribune Benefits Department, 1st Floor, 425 Portland Avenue, Minneapolis, MN 55488, fax number 612-673-7584, by Nov. 23, 2011 in order to have adult child medical coverage in 2012.

Adult Child Eligibility Policy: Employees are allowed to cover an eligible child, age 19 until age 26, under our medical plan, unless the child is eligible for employment-based medical coverage through the child's own employer, or, if the child is married, through the child's spouse's employer. If eligible for employment-based medical coverage, the adult child is not eligible for medical coverage with Star Tribune. Please note: These rules apply only to medical coverage. Different rules apply for coverage of your eligible children under our other programs, such as dental.

SECTION I – EMPLOYEE INFORMATION (Please print)

Employee Name: _____ Employee ID #: _____

SECTION II – ADULT CHILD ELIGIBILITY

Complete if you are covering your age 19 - 26 child under a Star Tribune-sponsored medical plan.

1. Name of adult child: _____
2. Is your adult child actively employed? Yes No
3. Name of adult child's employer: _____
Employer's address: _____
4. Is your adult child eligible for medical coverage from his/her employer? Yes No
5. If your adult child is married, is his/her spouse actively employed? Yes No
 Not applicable because not married
6. Name of adult child's spouse's employer: _____
Employer's address: _____
7. Is your adult child eligible for medical coverage from his/her spouse's employer? Yes No

SECTION IV – CERTIFICATION

I certify that the information provided above is correct as of the date below. I agree to notify Star Tribune within 31 days if there is any change in the information provided above. I understand that I will need to re-certify the information provided above at every annual enrollment. I understand that if I falsely certify the eligibility of the person listed above, if I otherwise misstate, misrepresent, or omit facts relevant to the eligibility of the person listed above, or if I fail to submit the documentation required as part of an eligibility review, or if I fail to update based on a change in eligibility, this could lead to disciplinary action, up to and including termination of my employment. I further understand that I may become liable for all benefits paid from the Plan on behalf of the person listed above (or any other ineligible individual that I have covered) for the period of time during which the person is ineligible for medical benefits from the Plan, and expenses associated with repayment of these benefits (including attorneys' fees).

Employee Signature

Date