XYZ COMPANY GROUP HEALTH PLAN
CERTIFICATION OF DEPENDENT CHILD TAX STATUS
FOR HEALTH COVERAGE PURPOSES (V.1)

If you are covering a child that is at least 18 years of age under the XYZ Company Group Health Plan (the "Plan"), you must complete this form, sign below and return the form to XYZ Company. Before making any certification in section 3 below, we recommend that you consult with a tax advisor.

1. Dependent Child Eligibility

A child of a covered employee will be eligible for coverage as a dependent under the Plan until the earlier of (a) such child's 26th birthday, or (b) 2 years after the end of the calendar year in which such child last qualified as a "qualifying child" or a "qualifying relative" as defined below.

A "qualifying child" is the child of the employee who, at the end of the calendar year, is either (a) under age 19, or (b) under age 24 if a full-time student for at least 5 months of the year, or (c) any age and permanently and totally disabled, with the same principal residence as the employee for more than half of the calendar year, and who does not provide more than half of his/her own support for the calendar year.

A "qualifying relative" is a child of the employee who receives more than half of his/her support from the employee for the calendar year and is not a "qualifying child" of any other taxpayer.

2. Imputed Income

If a child is covered under the Plan for any period after he/she is no longer a "qualifying child" or a "qualifying relative,"(i.e. the 2-year extension period described in 1(b) above -- the "extension period"), the employee will have imputed income for federal income tax purposes based on the fair market value of such coverage. That imputed income is subject to federal income tax withholding.

3. Certification

I certify that _____ [name of child] __ / __ / __ [DOB]

☐ Qualifies as either my "qualifying child" or "qualifying relative" as defined above in the current tax year.

OR

☐ Does not qualify as either my "qualifying child" or "qualifying relative" as defined above in the current tax year.

This document should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and you are urged to consult a lawyer concerning your own situation and any specific legal questions you may have.

I agree to immediately notify XYZ Company if the above named child covered under the Plan ceases to be either my qualifying child or qualifying relative as defined above, including any change that may occur mid-year. I understand that any change in such status may result in retroactive application of taxes to amounts previously paid for health coverage under the Plan during the year.

I understand I will be responsible for any costs or expenses (including tax penalties) that XYZ Company incurs as a result of its reliance on this certification, or if I fail to promptly notify XYZ Company of any loss of qualifying child or qualifying relative status of the above-named child.

_____
Employee Signature

_____
Print Name

Date: _____

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