# CCPU Health Care Reimbursement Fund - Dependent Coverage Enrollment Form

# 2025

This form must be filled out to add family dependents to your CCPU Healthcare Reimbursement benefits.

In order to be **complete**, you must also attach proof of coverage and proof of tax household to be eligible.
*(Please see Section B for guidance)*

*Please return this completed application to:*

**benefits@ccpuhealth.org**

*or*

**CCPU Health Care Reimbursement Fund**
Family Benefits
PO Box 57027
Irvine, CA 92619

Customer Service: 1-833-714-6028

# A Provider/Dependent Information

**COMPLETE ALL SECTIONS**

| CCPU Provider Last | First | Middle | Age |
|---|---|---|---|
| Birthdate (MM/DDYYY/Y) | Health Care Fund ID U-Number | | Gender: ☐ Male ☐ Female |
| Home Phone | Work Phone | E-mail Address | |

| **Physical Address (Required if the Childcare provider needs to update their address )** | | |
|---|---|---|
| Home Address | | County |
| City | State | ZIP |

| **Mailing Address (if different than listed above)** | | |
|---|---|---|
| Mailing Address | | County |
| City | State | ZIP |

**List all dependents you would like to add (attach additional pages if needed)**

| **Name** *(Last, first, middle initial)* | Full Time Student? | **Gender** | **Birthdate** | **Relationship** | **SSN** |
|---|---|---|---|---|---|
| **Spouse/Domestic Partner:** | ☐ | | | | |
| **Child:** | ☐ | | | | |
| **Child:** | ☐ | | | | |

# B Proof of Eligibility

**Dependents:** A child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction.

**Spouse**: an individual who is lawfully married to another individual.

**Registered Domestic Partner (RDP)**: individuals of the same sex and opposite sex who are in registered domestic partnerships, unions or other similar formal civil relationships that are not marriages under state law.

**Tax Household**: The taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. A tax household may include a spouse or dependents.

The provider must attach a copy of ***one*** of the following documents showing dependent/spouse/RDP eligibility and effective date:

1. Copy of qualified health plan billing statement showing dependents/spouse/RDP covered on same health plan as the provider; or
2. Copy of employer-sponsored coverage open enrollment benefits confirmation showing dependents/spouse covered on same plan as the childcare provider; or

If the childcare provideris enrolled in a Medicare plan or has a split household between Covered California and Medi-Cal, they must attach *one* document from List A showing effective date and at least *one* document from List B:

**List A**
1. A copy of a Medicare premium billing statement or
2. Medi-Cal verification of benefits form, or
3. A copy of your Covered California health plan summary pages

**List B**
1. Marriage Certificate
2. Birth Certificate or Adoption Decree
3. Tax Document verifying tax household (prior year or current year only)

# C Sign & Acknowledge

I understand that I am applying for CCPU Health Care Reimbursement benefits to be extended to my family members. I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect for my family members until the application and accompanying documents are verified and accepted.

1. If approved, family members will only maintain Health Care Fund benefits as long as the primary childcare provider maintains eligibility.
2. If dependents are added, they can only remain on these benefits until the age of 26, and they will be removed at the end of their birthday month. (Exceptions apply if the dependent is an overage disabled dependent.)
3. If any household member becomes a childcare provider and begins receiving state subsidized payments for the care of a child, they can be removed from their family plan and begin their own CCPU Health Care Reimbursement benefits as long as they meet eligibility criteria

_____ **CCPU Childcare provider MUST Initial here showing you have read and understand the paragraph above**

I, the undersigned, understand and agree that this is an addendum to my application to add healthcare benefits for my spouse, domestic partner, and/or dependents.

I attest that the information in this application addendum is true and accurate.
I understand that if I provide incomplete, or misleading information, my application and this addendum may be denied, my participation in the CCPU Health Care Fund may be terminated, and my claims may be denied.
I will inform the CCPU Health Care Fund about any changes to the information in this application within 30 days of the change.
I also understand that submitting this application does not guarantee benefits for my family or enroll my family in a health benefit plan or health insurance coverage through Covered California or any other insurance carrier.
I agree to indemnify and hold the CCPU Health Care Fund and the Board of Trustees harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

Signature: Date: