

**EMPLOYEE ACKNOWLEDGEMENT  
OF RESPONSIBILITY FOR  
CHANGES IN DEPENDENT BENEFIT**

1. NOTICE REQUIRED UPON FAMILY STATUS CHANGE An employee participating in the City of Rochester benefit program (including the opt down/out incentive) must notify the Human Resources office within thirty (30) days of any of the following family status change events. Such notice must be submitted in writing utilizing an Application and Change Form:
- Birth
  - Adoption
  - Marriage
  - Divorce
  - Death of a spouse or dependent child
  - Change in employment status of spouse (when change in benefit is required)
  - Dependent turns 26

Please note, changes in benefit coverage generally take effect on the first of the month following notification of the family status change.

Failure to submit the required notification may result in loss of benefits for the otherwise eligible dependents, employee liability for reimbursing ineligible benefit plan expenses, and/or disciplinary action up to and including termination of employment.

2. PROOF OF RELATIONSHIP Certified documents legally establishing a dependent relationship are required to be presented and verified to the Payroll office prior to establishing medical and/or dental coverage for a spouse and/or child(ren).

<u>Spouse/Child(ren) Name</u>	<u>Date of Birth</u>	<u>Document Shown</u>	<u>Date</u>

3. ACKNOWLEDGEMENT As a benefit eligible employee of the City of Rochester, I have read and understand the requirements above. I have provided the necessary documentation to establish an eligible dependent relationship for coverage under the City of Rochester's benefit program. I hereby certify that all of the oral information and written documentation that I have presented are true, correct and authentic to the full extent of my knowledge and understanding. I am aware of my responsibility to promptly notify the City of Rochester of any family status change that necessitates a change in benefit coverage (inclusive of the opt out/down incentive).

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Payroll/Benefits Administrator

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date