University of Nebraska

TERMINATION OF EMPLOYEE PLUS ONE RELATIONSHIP FORM/ TERMINATION OF TAX-QUALIFIED DEPENDENT STATUS FORM

Instructions: *Submit this completed form to your Campus Benefits Office to notify the University of Nebraska or your Employer, as applicable, of a termination of an Employee Plus One relationship and/or a termination of tax dependent status of an Employee Plus One dependent. Sign only the section(s) applicable to your situation.*

EMPLOYEE INFORMATION:

Employee Name (Last, First, MI): _____ NU ID: _____

Date of Birth:_____/_____/_____ Gender: _____ Social Security Number: _____-_____- _____

Address: _____ City: _____ State:_____Zip: _____

ADULT DESIGNEE INFORMATION:

Adult Designee Name (Last, First, MI): _____ NU ID: _____

Date of Birth:_____/_____/_____ Gender: _____ Social Security Number: _____-_____- _____

Address: _____ City: _____ State:_____Zip: _____

Relationship Ended On: ____/_____/_____

ADULT DESIGNEE DEPENDENT CHILD INFORMATION: List only the Adult Designee's child(ren) who were listed on the original Affidavit of Employee Plus One Relationship form and Tax-Qualified Dependent Certification for Employee Plus One Benefits form.

Name (Last, First, MI): _____ SSN: ____- ____- _____ DOB: ___/____/_____

Name (Last, First, MI): _____ SSN: ____- ____- _____ DOB: ___/____/_____

Name (Last, First, MI): _____ SSN: ____- ____- _____ DOB: ___/____/_____

Name (Last, First, MI): _____ SSN: ____- ____- _____ DOB: ___/____/_____

TERMINATION OF EMPLOYEE PLUS ONE RELATIONSHIP CERTIFICATION: I certify that as of _____(date) my Employee Plus One relationship with my Adult Designee and/or my Adult Designee's dependent child(ren) designated above terminated. I understand that to register another Adult Designee I must wait 12 months from this date. I further understand that Employee Plus One eligibility for University of Nebraska sponsored benefits ends on the last day of the month following the date of my Adult Designee's change in status and/or my Adult Designee's dependent child's change in status. Failure to notify the University of Nebraska or my Employer, as applicable, within 31 days of the termination date of the relationship may result in liability for benefits paid for ineligible individuals and disciplinary action (including cancellation of my benefits or termination of my employment). I certify that the information supplied on this form is true and complete, and I understand that any false information or statements made on this form will be grounds to void my coverage and/or terminate my employment.

Employee Signature: _____Date: _____/_____/_____

TERMINATION OF STATUS AS A TAX QUALIFIED DEPENDENT CERTIFICATION: I certify that as of _____(date) the person (or persons) designated above no longer qualifies as my federal tax dependent under the Internal Revenue Code. Failure to notify the University of Nebraska or my Employer, as applicable, within 31 days of the date of the dependent's change in status may result in disciplinary action (including termination of my employment). I understand that my failure to provide notice of a dependent's change in federal tax dependent status may result in liability for taxes, penalties, or other losses (including reasonable attorneys' fees) that the University of Nebraska or my Employer, as applicable, may incur as a result of my failure to provide notification of my dependent's change in status. I further understand that my dependent's eligibility for University of Nebraska sponsored benefits ends on the date the dependent no longer meets the University of Nebraska's eligibility requirements as outlined at www.nebraska.edu/benefits. I certify that the information supplied on this form is true and complete, and I understand that any false information or statements made on this form will be grounds to void my coverage and/or terminate my employment.

Employee Signature: _____Date: _____/_____/_____