**SECTION [V]**

*{Drafting Note: Insert the appropriate section number, following the*

*order of provisions in the Table of Contents.*

*This section is required for stand-alone dental insurance*

*that covers the Student and dependent children.}*

**Who Is Covered**

**A. Who is Covered Under this Certificate.**

You, the Student to whom this Certificate is issued, are covered under this Certificate. [Members of Your family may also be covered depending upon the type of coverage You selected.]

*{Drafting Note: Coverage of Dependents is optional, if coverage is provided the bracketed language must be used.}*

**B. Types of Coverage.**

We offer the following [types of] coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

**[2]**. [**Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.]

**[3.]** [**Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.]

**[4.]** [**Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.]

*{Drafting Note: Coverage of Dependents is optional, if Spouses and Children are covered use the above language as applicable.}*

[**C.**][**Children Covered Under this Certificate.**

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the [day; end of the [month; year] in which] the Child turns [19] years of age. [Any unmarried Child who is a student at an accredited institution of learning is considered a Child until age [23] and coverage will last until the [day; end of the [month; year] in which] the Child turns [23] years of age.] [Coverage also includes Children for whom You are a [permanent] legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.] [[Foster Children] [and] [grandchildren] are not covered.] [[Grandchildren who are chiefly dependent upon You for support [and who live with You]] [and] [[F;f]oster children] are covered.]]

{*Drafting Note: Dependent children must be covered until at least the end of the month that the child turns 19 years of age and Dependents who are students must be covered to at least age 23. The bracketed language beginning “Any unmarried Child who is a student” can be removed if all children are covered to age 23 or higher. Plans may extend coverage to foster children, grandchildren and children for whom the subscriber is a legal guardian. If coverage is extended to grandchildren, the bracketed “and who live with you” language is optional.}*

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

*{Drafting Note: If Children who are students at an accredited institution of learning and other children are covered to the same age of at least 23 or higher the paragraph below may be deleted.}*

[Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child’s Physician who is licensed to practice in the state of New York.]

*{Drafting Note: The paragraph below is optional.}*

[We also cover additional Dependents under this Certificate including [siblings,] [parents,] [grandparents,] [Spouse’s parents,] and [Spouse’s grandparents], if these additional Dependents are chiefly dependent upon You for support [and live with You].]

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Student and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.]

[**D.**] **When Coverage Begins.**

Coverage under this Certificate will begin as follows:

1. If You, the Student, elect coverage before becoming eligible, or within [30] days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your [Contractholder; Policyholder.]

*{Drafting Note: Plans must use a minimum of 30 days.}*

1. [If You, the Student, do not elect coverage upon becoming eligible or within [30] days of becoming eligible for other than a special enrollment period, You must wait until the [Contractholder’s; Policyholder’s] next open enrollment period to enroll, except as provided below.]

*{Drafting Note: Insert paragraph if plan elects to have an open enrollment period. If an open enrollment period is used, plans must use a minimum of 30 days.}*

1. [If You, the Student, marry while covered, and We receive notice of such marriage and Premium payment within [30] days thereafter, coverage for Your Spouse [and Child] starts on [the first day of the following month after We receive Your application; the date of the marriage.] If We do not receive notice within [30] days of the marriage, You must wait until the [[Contractholder’s; Policyholder’s] next open enrollment period; first day of the following month after We receive Your application] to add Your Spouse [or child].]

*{Drafting Note: If Spouses are covered insert the paragraph above. Insert the bracketed language about Children if Children are covered. Plans must use a minimum of 30 days. Plans may select either bracketed options.}*

1. [If You, the Student, have a newborn or adopted newborn Child and We receive notice of such birth within [30] days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within [30] days of the infant’s birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within [30] days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.]

*{Drafting Note: If Children are covered insert the paragraph above. Plans must use a minimum of 30 days.}*

[**E.**] **Special Enrollment Periods.**

You [[Your Spouse] [or] [Child]] can enroll for coverage within [30] days of the loss of coverage in a dental plan if coverage was terminated because You[, Your Spouse] [or] [Child]] are no longer eligible for coverage under the other dental plan due to:

1. Termination of employment;

2. Termination of the other dental plan;

3. Death of the Spouse;

4. Legal separation, divorce or annulment;

5. Reduction of hours of employment;

6. Employer contributions towards the dental plan were terminated for You [or Your Dependent’s] coverage; or

7. A Child no longer qualifies for coverage as a Child under the other dental plan.

*{Drafting Note: Plans must use a minimum of 30 days. Insert the bracketed language in item 6 if the plan covers dependents.}*

You[, [and] Your [Spouse] [or] [Child]] can also enroll [30] days from exhaustion of Your COBRA or continuation coverage [or if You [gain a Dependent] [or] become a Dependent through marriage, birth, adoption or placement for adoption.]

*{Drafting Note: Plans must use a minimum of 30 days. Insert “or if You gain a Dependent…” if the plan covers dependents.}*

We must receive notice and Premium payment within [30] days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. [If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.]

*{Drafting Note: Plans must use a minimum of 30 days. Insert the last sentence if the plan covers dependents.}*

In addition, You[, [and] Your [Spouse] [or] [Child],] can also enroll for coverage within 60 days of the occurrence of one of the following event:

1. You [or Your [Spouse] [or] [Child]] lose[s] eligibility for Medicaid or a state child dental plan; or
2. You [or Your [Spouse] [or] [Child]] become eligible for Medicaid or state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

*{Drafting Note: If the plan covers Spouses, domestic partner coverage must be included. Include the second sentence if the plan covers Children.}*

[**F. Domestic Partner Coverage.**

This Certificate covers domestic partners of Students as Spouses. [If You selected family coverage, Children covered under this Certificate also includes the Children of Your domestic partner.] Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or
2. For partners residing where registration does not exist, by:
   1. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:

* The partners are both 18 years of age or older and are mentally competent to consent to contract;
* The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
* The partners have been living together on a continuous basis prior to the date of the application;
* Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
  1. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
  2. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
* A joint bank account;
* A joint credit card or charge card;
* Joint obligation on a loan;
* Status as an authorized signatory on the partner’s bank account, credit card or charge card;
* Joint ownership of holdings or investments;
* Joint ownership of residence;
* Joint ownership of real estate other than residence;
* Listing of both partners as tenants on the lease of the shared residence;
* Shared rental payments of residence (need not be shared 50/50);
* Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
* A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
* Shared household budget for purposes of receiving government benefits;
* Status of one (1) as representative payee for the other’s government benefits;
* Joint ownership of major items of personal property (e.g., appliances, furniture);
* Joint ownership of a motor vehicle;
* Joint responsibility for child care (e.g., school documents, guardianship);
* Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
* Execution of wills naming each other as executor and/or beneficiary;
* Designation as beneficiary under the other’s life insurance policy;
* Designation as beneficiary under the other’s retirement benefits account;
* Mutual grant of durable power of attorney;
* Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
* Affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
* Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.]