

VERIFICATION FORM FOR ADDING OR DROPPING DEPENDENT BENEFITS

Please review the "Required Documents Worksheet for Adding and Dropping Dependents" and confirm your dependents are eligible or not eligible for coverage by completing the information below and providing the documentation required on the document list. Please only complete the last column if disenrolling a dependent. All other columns must be completed. **Please return completed form with required documents to your agency benefits specialist.**

Employee Name (print)		Employee ID		
Date of Event for Adding/Disenrolling Dependent:				
Dependent Name	Relationship	Dependent Type	Is dependent eligible for coverage?	Reason for disenrolling dependent
	Spouse	<input type="checkbox"/> Legally Married <input type="checkbox"/> Common Law	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Legal Separation
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMSCO <input type="checkbox"/> House Bill 1 <input type="checkbox"/> Student (dental/vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> End of QMSCO <input type="checkbox"/> No longer eligible for coverage
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMSCO <input type="checkbox"/> House Bill 1 <input type="checkbox"/> Student (dental/vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> End of QMSCO <input type="checkbox"/> No longer eligible for coverage
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMSCO <input type="checkbox"/> House Bill 1 <input type="checkbox"/> Student (dental/vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> End of QMSCO <input type="checkbox"/> No longer eligible for coverage

Dependent Name	Relationship	Dependent Type	Is dependent eligible for coverage?	Reason for disenrolling dependent
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMSCO <input type="checkbox"/> House Bill 1 <input type="checkbox"/> Student (dental/vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> End of QMSCO <input type="checkbox"/> No longer eligible for coverage
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMSCO <input type="checkbox"/> House Bill 1 <input type="checkbox"/> Student (dental/vision)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Death <input type="checkbox"/> End of QMSCO <input type="checkbox"/> No longer eligible for coverage

Contact Information

Please provide the following information where you can be reached if we have questions about your dependent's eligibility for benefits coverage.

Telephone: _____

Best time to call: _____

E-mail Address: _____

Mailing Address: _____

By signing this form, I attest that I have reviewed the Dependent Eligibility Definitions and that the information I am submitting is true and accurate. I understand that knowingly providing false or misleading information in this form may result in any or all of the following actions by the State of Ohio: 1) disciplinary action, up to and including removal; 2) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 3) civil and/or criminal prosecution.

Signature

Date

ADM-BAS 4020