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	☐ Legally Married ☐ Common Law	☐ Yes ☐ No	☐ Death ☐ Divorce ☐ Legal Separation ☐ Other Coverage
	Child	☐ Biological ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Legal Guardianship ☐ QMSCO ☐ House Bill 1 ☐ Student (dental/vision)	☐ Yes ☐ No	☐ Death ☐ End of QMSCO ☐ No longer eligible for coverage ☐ Other Coverage
	Child	☐ Biological ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Legal Guardianship ☐ QMSCO ☐ House Bill 1 ☐ Student (dental/vision)	☐ Yes ☐ No	☐ Death ☐ End of QMSCO ☐ No longer eligible for coverage ☐ Other Coverage
	Child	☐ Biological ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Legal Guardianship ☐ QMSCO ☐ House Bill 1 ☐ Student (dental/vision)	☐ Yes ☐ No	☐ Death ☐ End of QMSCO ☐ No longer eligible for coverage ☐ Other Coverage

Dependent Name	Relationship	Dependent Type	Is dependent eligible for coverage?	Reason for disenrolling dependent
	Child	☐ Biological ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Legal Guardianship ☐ QMSCO ☐ House Bill 1 ☐ Student (dental/vision)	☐ Yes ☐ No	☐ Death ☐ End of QMSCO ☐ No longer eligible for coverage ☐ Other Coverage
	Child	☐ Biological ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Legal Guardianship ☐ QMSCO ☐ House Bill 1 ☐ Student (dental/vision)	☐ Yes ☐ No	☐ Death ☐ End of QMSCO ☐ No longer eligible for coverage ☐ Other 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