



STATE OF OHIO
Annual Affidavit of Student Status

Agency Name: _____

I, _____, after first being duly cautioned and sworn, state that:

My unmarried dependent _____ is 19 – 22 years of age, and
(Name of Dependent)
attends _____.
(Name of Accredited School)

I have attached a copy of a letter from the registrar with the dependent's name, semesters/quarters enrolled in the prior 12 months, and a school phone number for the above-referenced dependent

OR

For dependents who are enrolling in college for the first time or who have not been enrolled for over a year:

I have attached a letter from the registrar and class schedule with the dependent's name, school name, and a school phone number for the above-referenced dependent.

This section must be completed

I have read and agree to comply with the terms and conditions that appear on the attached "Instructions for Completing Annual Affidavit of Student Status."

Signature of Employee

Employee Identification Number

Sworn to before me and subscribed to in my presence this _____ day of _____, _____

Notary Public

INSTRUCTIONS FOR COMPLETING
Annual Affidavit of Student Status

Terms and Conditions:

1. I have read and agree to the provisions in the Department of Administrative Services, Benefits Administration Services Web site and/or the summary plan descriptions for the plan year in which I am enrolling my student. Specifically, I have read and agree to the eligibility rules provided at das.ohio.gov/Divisions/HumanResources/BenefitsAdministration/Medical/tabid/199/Default.aspx. My signature certifies that my dependent that I am enrolling for benefit coverage complies with these rules. I understand that the enrolling of an ineligible dependent may be considered fraud and could result in disciplinary actions up to and including but not limited to employment termination and/or reduction of retirement benefits. I also understand that I may be required to supply copies of documentation such as certified birth certificate(s), front/last page of income tax returns and other related documentation.
2. If enrolling for coverage, which I understand is voluntary, I authorize the deduction from my paycheck for the cost of coverage, which I have elected. I understand that payment on a pre-tax basis means that my gross pay will be reduced by the cost of the coverage before any applicable taxes are deducted.
3. I acknowledge that the information on this Annual Affidavit of Student Status Form is complete and accurate. I understand that the information provided on this Form is used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or revoke coverage.
4. I cannot start, stop, or change any pretax election until the next open enrollment unless I experience a change in family status or my dependent student discontinues school or reaches the age of 23.
5. I acknowledge the requirement that my and my dependent's social security numbers may be used as identifiers, as required under the Health Insurance Portability and Accountability Act (HIPAA).
6. Unless otherwise prevented by law, I authorize, for myself and my dependent, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information to the insurance provider or its authorized representatives.
7. I understand it is my responsibility to notify my employer if an enrolled dependent drops out of school.

Furthermore, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care.