



VERIFICATION FORM FOR DEPENDENT BENEFITS

Please review the Definition of Eligible Dependents and confirm your dependents are eligible for coverage by completing the information below and providing the documentation required on the Definitions and Required Documents for Dependent Eligibility checklist.

Please return completed form with required documents to your agency benefits representative.

Employee Name (print)		Employee ID	
Dependent Name (print name of each dependent below)	Relation (e.g. spouse, son, disabled dependent, etc.)	Dependent type (Check all boxes that apply for each dependent)	Is dependent eligible for coverage?
	Spouse	<input type="checkbox"/> Legally Married <input type="checkbox"/> Common Law	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Disabled <input type="checkbox"/> Student (19-22) <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> House Bill 1	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Disabled <input type="checkbox"/> Student (19-22) <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> House Bill 1	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Disabled <input type="checkbox"/> Student (19-22) <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> House Bill 1	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Disabled <input type="checkbox"/> Student (19-22) <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Qualified Medical Child <input type="checkbox"/> Support Order <input type="checkbox"/> House Bill 1	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Disabled <input type="checkbox"/> Student (19-22) <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Qualified Medical Child <input type="checkbox"/> Support Order <input type="checkbox"/> House Bill 1	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Contact Information

Please provide the following contact information where you can be reached for 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 and documentation I am submitting are 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) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

 Signature of Enrolled Employee

 Date

For questions, please call HCM Customer Service Unit at 1.800.409.1205.