



BENEFITS DIRECT PAYMENT FORM

The following information must be completed by the Employing Agency:

EMPLOYEE or BOARD/COMMISSION MEMBER NAME: _____

EMPLOYEE ID _____ MONTHLY COVERAGE AMOUNT DUE \$ _____

HEALTH PLAN: _____ Sgl/Fam/FamSpouse _____ \$ _____

DENTAL PLAN: _____ Sgl/Fam/FamSpouse _____ \$ _____

VISION PLAN: _____ Sgl/Fam/FamSpouse _____ \$ _____

AGENCY NAME: _____

AGENCY CONTACT NAME: _____ PHONE # _____

PAYMENT FOR: _____ Board/Commission Member _____ Leave of Absence _____ Military Pay _____ Workers Comp (Exempt ONLY)

The following information must be completed by the employee or Board/Commission Member:

EMPLOYEE or BOARD/COMMISSION MEMBER PHONE # _____ (If not reachable, please indicate an emergency contact name & # below)

EMERGENCY CONTACT _____ PHONE # _____

AMOUNT ENCLOSED: \$ _____ MONTH(S) COVERED: _____

Attach a check or money order made payable to "Ohio Treasurer of State" to this form and forward to:

DAS/HRD Business Office
Attention: Pay Fiscal Services
30 E. Broad St., 27th Floor
Columbus, Ohio 43215

If you have any questions, call DAS/HRD/HCM Customer Service at 1-800-409-1205.



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