



## 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 (Incl Comm Surchg, MH Chg) \$ \_\_\_\_\_

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

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

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

If the employee is on FEDERAL military leave or during the 12 week allowable FMLA, only indicate the EMPLOYEE's share of the cost.

AGENCY NAME: \_\_\_\_\_

AGENCY CONTACT NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

PAYMENT FOR:  Board/Commission Member  FMLA  Leave of Absence  Military Leave  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.**



## 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 (Incl Comm Surchg, MH Chg) \$ \_\_\_\_\_

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

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

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

If the employee is on FEDERAL military leave or during the 12 week allowable FMLA, only indicate the EMPLOYEE's share of the cost.

AGENCY NAME: \_\_\_\_\_

AGENCY CONTACT NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

PAYMENT FOR:  Board/Commission Member  FMLA  Leave of Absence  Military Leave  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.**