

BENEFIT DIRECT PAYMENT FORM

EMPLOYEE/BD MEMBER NAME: _____

EMPLOYEE ID _____ MONTHLY COVERAGE AMOUNT DUE _____

HEALTH PLAN: _____ S/F _____ AMOUNT _____

DENTAL PLAN: _____ S/F _____ AMOUNT _____

VISION PLAN: _____ S/F _____ AMOUNT _____

AMOUNT ENCLOSED _____ MONTH(S) COVERED _____

DEPT NAME: _____ PHONE# _____ - _____ - _____

DEPT CONTACT NAME: _____

Send check or money order made payable to "Ohio Treasurer of State" with this form to:

DAS Payroll Department
ATTN: Debbie Killian
30 E Broad Street - 29th Floor
Columbus, Ohio 43215

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