Ohio Legislation – Dependents to Age 28

OH28 MEDICAL ENROLLMENT APPLICATION

DEPENDENT INFORMATION		
Dependent Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Full-Time Student: Yes ☐ No ☐	Resident of State of OH: ☐Yes ☐No	Marital Status: ☐Single ☐Married
If Yes, name of College:		
City:	State:	ZIP Code:
Currently Employed: Yes☐ No☐	Employer Name:	
Address:		
City:	State:	ZIP Code:
Employer Phone #:		

EMPLOYEE INFORMATION		
Employee Name:		
Date of birth:	SSN:	
Current address:		Phone:
City:	State:	ZIP Code:
District:		

READ THE BELOW INFORMATION:

By my signature of this form, I certify and warrant to my employer that all information on this form is true, correct and current as of the date signed and any attempt to enroll for/or maintain coverage for an ineligible dependent will be subject to appropriate disciplinary action. I understand I will be responsible for any claim payments made for ineligible dependents.

I authorized my district to deduct with after tax dollars the premium cost of this coverage. Failure to pay premium will result in termination of coverage.

Signature of Employee:	Date:

TO BE COMPLETED BY THE DISTRICT
Signature of Employer:
Date:

DOCUMENTATION REVIEWED		
Documentation:	College Transcript	Birth Certificate