State of Ohio Extension of Dependent Coverage Form

For Ages 26-28

Employee _____

Employee ID# _____ Social Security Number _____

Department/Division work location _____

Work phone # _____ Home phone # _____

Cell phone # _____ Email address _____

Eligible Dependent

Name of Dependent _____ Date of Birth _____

Relationship _____ Social Security number _____

Dependent's Address _____

Has other insurance Yes __ No ___ Insured 's Name _____

Name of insurance carrier _____

Policy # _____ ID # _____

Supporting documentation includes: birth certificate; adoption papers; driver's license; and school schedule.

To receive benefits up to the age of 28, the dependent child must be: the natural child, step-child, or adopted child of the employee (dependents covered under guardianship or custody papers are NOT eligible for this extended coverage); a resident of the State of Ohio or a full time student at an institution of higher learning; unmarried; not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and is not eligible for coverage under Medicaid or Medicare.

I certify all information is true and correct to the best of my knowledge. I understand that by applying for this coverage, I authorize the City of Cincinnati to deduct from my wages, the required premiums for the coverage hereon applied for. I further authorize any provider of medical, dental, or vision services, insurance company or any other organization to release to Anthem Blue Cross & Blue Shield any information regarding my coverage.

Employee signature _____ Date _____

Risk Management Use Only

Coverage effective date:

_____

Form IN-04
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