THE OHIO STATE UNIVERSITY

Affidavit of Sponsored Dependency

For Benefit Coverage

I, _____ _____
Employee's Full Name OSU Employee ID#

hereby request health plan coverage for my sponsored dependent, _____
Name of Sponsored Dependent

and certify that all of the following are true:

1. The sponsored dependent resides at the same principal place or abode as I do and is a member of my household for the entire tax year during which sponsored dependent coverage is provided.
2. The sponsored dependent shares a relationship with me as defined by one of the following:
   - My parent, step-parent, parent-in-law or person who stood in loco parentis to me as a child
   - My grandparent or grandparent of my spouse
   - My sibling or sibling-in-law
   - My aunt, uncle, niece or nephew
   - My son- or daughter-in-law, grandchild or spouse of my grandchild
   - My biological, adopted, step or foster child who is not otherwise eligible for coverage under the terms of Ohio State's group health plans
   - My opposite-sex domestic partner who is unmarried, and with whom I am not related by blood to a degree of closeness that would prohibit marriage in the state in which we legally reside, and with whom I have been in a relationship for at least six months and intend to remain so indefinitely
   - My enrolled opposite sex-domestic partner's dependent child
3. The sponsored dependent is dependent upon me for more than 50% of his or her support. I can provide documentation of such support to the Office of Human Resources or to Ohio State's Third Party Administrator for claims administration, if requested, to verify the dependent status of this individual. Support includes:
   - Housing/shelter
   - The cost for his or her clothing, food, education, recreation and transportation
   - The cost for his or her medical, dental and/or vision care
   - The cost for a proportionate share of other expenses necessary to support the sponsored dependent within my household (such as food and utilities), but which cannot be directly attributed to that dependent
4. The sponsored dependent is enrolled in Medicare if he or she is eligible for such coverage, and I understand that Ohio State's health plan will be a secondary payor to Medicare.
5. The sponsored dependent is my dependent under Section 152 of the Internal Revenue Code of 1986, as amended. (Please consult with a tax advisor if you have any questions regarding whether or not the sponsored dependent meets the IRS qualifications.)
   - I agree to file an Affidavit of Termination of Same-Sex Domestic Partnership and/or Sponsored Dependency Status, with the Office of Human Resources, and will mail a signed copy to the former sponsored dependent, within 31 days of any change in the circumstances attested to in this Affidavit that would make my sponsored dependent ineligible for coverage under the terms of Ohio State's benefits plans.
   - I understand that I cannot file another Affidavit to establish health care eligibility for the same individual whose coverage was terminated via an Affidavit of Termination of Same-Sex Domestic Partnership and/or Sponsored Dependency Status, or for any other individual with whom I intend to establish eligibility as an opposite-sex domestic partner, for at least six months following the date that an Affidavit of Termination of Same-Sex Domestic Partnership and/or Sponsored Dependency Status was filed with the Office of Human Resources.
   - I certify that the information provided in all parts of this Affidavit is true, accurate and complete. I understand that a false declaration of sponsored dependency, material omission of information on this Affidavit or failure to timely inform Ohio State of the termination of a sponsored dependency is considered fraud and may result in disciplinary action of an employee up to and including termination of benefits and/or employment. I also agree that Ohio State may recover damages for all losses (including paid claims) and reasonable attorneys' fees incurred to recover such damages.

_____
Signature of Employee | Date | Date of Birth | Daytime Phone Number | Email

Sworn to and subscribed in my presence this _____ day of _____
Date Month Year

(Seal) _____
Signature of Notary Public

Complete a separate affidavit for each sponsored dependent for whom you are requesting health care coverage.
Review dependent eligibility guidelines online at **hr.osu.edu/benefits/benefitseligibility.aspx**. Refer to premium rate information on reverse or online at **hr.osu.edu/benefits/hb_rates**. If you have questions, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, **hr.osu.edu**, **614-292-1050**, **800-678-6010**.

Return completed form to: The Ohio State University, Office of Human Resources, Benefits Processing/SD, 1590 N. High St., Suite 300, Columbus, OH 43201-2190; fax: **614-292-7813**