

Affidavit of Sponsored Dependency

(For Health Care Coverage)

This form is to be completed when applying for health benefits for your eligible sponsored dependents. Return the completed Affidavit along with the applicable benefit election form(s) to the Office of Human Resources.

I, _____
Faculty/Staff Member (print) OSU Employee ID Number _____

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

and certify that **all** of the following are true:

(Complete a separate Affidavit for each sponsored dependent for whom you are requesting health care coverage.)

1. The sponsored dependent resides at my permanent residence and is expected to reside as 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-in-law
 - My sibling or sibling-in-law
 - My aunt, uncle, niece, or nephew
 - My son- or daughter-in-law, grandchild, or grandchild-in-law
 - My biological, adopted, step, or foster child who is not otherwise eligible for coverage under the terms of the university'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 (6) months and intend to remain so indefinitely
3. The sponsored dependent is financially dependent upon me for more than 50% of his or her financial support, in accordance with the plan requirements outlined by Ohio State. Financial dependency is demonstrated by the sum of the following and I can provide documentation of such to the Office of Human Resources or to the university's third party administrator for claims administration, if requested, to verify the dependent status of this individual:
 - The rental value of housing
 - The cost for his or her clothing, education, recreation, and transportation expenses
 - 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 the dependent
4. The sponsored dependent is enrolled in Medicare if he or she is eligible for such coverage, and I understand that the university's health plan will be a secondary payor to Medicare.
 - I agree to file an Affidavit of Termination of Sponsored Dependency Status or an Affidavit of Termination of Domestic Partnership Status (for an opposite-sex domestic partner), as appropriate, 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 the university's health plans.
 - I understand that I cannot file another Affidavit to establish health plan eligibility for the same individual whose coverage was terminated via an Affidavit of Termination of Sponsored Dependency Status or for any other individual with whom I intend to establish eligibility as a domestic partner, for at least six (6) months following the date that an Affidavit of Termination 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 Faculty/Staff Member _____ Date of Birth _____ Date _____

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

(Seal)

Signature of Notary Public

If you have questions, contact the Office of Human Resources Customer Service
Center at service@hr.osu.edu, hr.osu.edu, (614) 292-1050, 1-800-678-6010.

Return completed form to: Office of Human Resources, Benefits Processing/SSDP,
1590 N. High St., Suite 300, Columbus, OH 43201-2190

