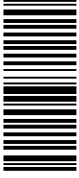


## Dependency Verification



Under the eligibility guidelines of Ohio State's health plans, faculty and staff may cover a dependent child to the age of 19, or to the age of 23 if the dependent continues to meet all of the other eligibility criteria established under the plans. The Dependency Verification process helps to identify any changes in dependent eligibility during the previous year, better enabling the university to manage its health plan eligibility, and thus, its plan costs. A complete definition of dependent eligibility can be obtained at: <http://hr.osu.edu/hrpubs/ben/medicalsdpd.pdf>.

It has been determined that your dependent referenced on the enclosed form is between the ages of 19 and 22, or will become age 19 on his or her upcoming birthday. In order to continue uninterrupted health coverage for this dependent, please complete the enclosed information and return it to NGS. You will be requested to verify continued eligibility for this dependent on an annual basis, as long as he or she remains covered under your plan. However, if any of the eligibility criteria for this dependent changes during the year, please notify the Ohio State Office of Human Resources within 31 days of the change.

Please provide the information listed in the enclosed Request for Dependency Verification Information form to NGS. This information can be provided to NGS via:

**Phone at: 1-877-647-0083 EXT. 13004; or**  
**Fax at: 1-586-258-1877; or**  
**Mail at: NGS American, Inc.**  
**P.O. Box 7676**  
**St. Clair Shores, MI 48080**

If you should have any questions, contact Bette Jo McKay with NGS American at 1-877-647-0083 EXT. 13004. You may also download this form from the Office of Human Resources web site at: <http://hr.osu.edu/forms/ben/ngsdepverify.pdf>.

Enclosure

# NGS REQUEST FOR DEPENDENCY VERIFICATION INFORMATION

Member ID.....:

Name of Dependent..:

**1. Indicate this dependent's relationship to you:**

Son \_\_\_\_\_ Daughter \_\_\_\_\_ Step-Son \_\_\_\_\_ Step-Daughter \_\_\_\_\_

Other (please specify) : \_\_\_\_\_

**2. Does this dependent reside at your primary residence for at least half of the year?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please indicate reason \_\_\_\_\_

**3. Marital status of this dependent:**

Single \_\_\_\_\_ Married \_\_\_\_\_

If married, please indicate date of marriage: \_\_\_\_\_

**4. Do you or your spouse provide at least 50% of this dependent's financial support\*?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please indicate effective date of dependency change: \_\_\_\_\_

\* **(Financial support** is defined as the sum of the rental value of housing for the dependent; the cost for his or her clothing, education, recreation and transportation expenses; the cost for his or her medical, dental, and/or vision care; and the cost for a proportionate share of other expenses necessary to support the dependent within your household (such as food and utilities) that cannot be directly attributed to the dependent.)

**For reporting purposes only (not used for eligibility determination)**

Please indicate which of the following applies to this dependent:

Dependent is a full-time student: \_\_\_\_\_

Dependent is a part-time student: \_\_\_\_\_

Dependent is not currently a student: \_\_\_\_\_

I understand that, as an Ohio State medical plan member, I have the responsibility to provide, when requested, complete and factual information to NGS relating to dependency verification, as specified in the Medical Plan Detail Document outlining program provisions for the university's medical plans. I further understand that any person who, knowingly and with intent to defraud, applies for coverage or files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

I certify that all information provided on this form is true and correct to the best of my knowledge, and understand that it is my responsibility to notify the Ohio State Office of Human Resources within 31 days of a change in dependent status.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

Thank you for completing this Request for Dependency Verification Information.  
Please respond to NGS American.

**Phone at: 1-877-647-0083 EXT. 13004; or**

**Fax at: 1-586-258-1877; or**

**Mail at: NGS American, Inc.**

**P.O. Box 7676**

**St. Clair Shores, MI 48080**

**IT IS IMPORTANT THAT YOU RESPOND TO THIS REQUEST IN ORDER TO ENSURE  
APPROPRIATE COVERAGE FOR YOUR DEPENDENT.**