Affidavit of Sponsored Dependency (For Benefit Coverage)

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:

1. The sponsored dependent resides at the same principal place or abode as me 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 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 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 benefit 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.

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Signature of Faculty/Staff Member   Date   Date of Birth   Daytime phone #   E-mail

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

(Seal)

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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**. 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, 1-800-678-6010.

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

Health Plan Contribution Rates for Sponsored Dependent Coverage

This chart contains the **pre-tax** contribution rates for **each** eligible sponsored dependent you cover under your health plan(s). The premiums are based on Medicare eligibility. If the sponsored dependent is Medicare-eligible, he or she **must** enroll for such coverage and the university's health plan will be secondary payor to Medicare. These rates are in addition to the rate deducted from your pay for coverage for yourself and any other covered dependents.

- The university does not provide a subsidy toward the cost of providing health plan coverage to sponsored dependents–employees are responsible for the full contribution amount(s).
- Employee contributions for sponsored dependent coverage are deducted from the employee's pay on a **pre-tax** basis.
- Contribution amounts for sponsored dependent coverage are actuarially determined and may differ from the full cost of providing coverage to an employee's spouse or eligible dependent child under the university's group health plans.

Medical Contributions per Sponsored Dependent

Plan	Biweekly		Monthly	
	Non-Medicare	Medicare-eligible[1]	Non-Medicare	Medicare-eligible[1]
Prime Care Advantage	$411.69	$202.15	$892.00	$438.00
Prime Advantage Value	$383.54	$199.85	$831.00	$433.00
Prime Advantage Plus	$458.77	$210.92	$994.00	$457.00
Independent Choice	$567.23	$214.62	$1,229.00	$465.00
Out-of-Area Plan[2]	$411.69	$202.15	$892.00	$438.00
Delta Dental Plan	$10.55	$10.55	$22.86	$22.86
Vision Service Plan	$3.59	$3.59	$7.78	$7.78

[1] If the sponsored dependent is Medicare-eligible, he or she *must* enroll for such coverage.
[2] Enrollment in these plans requires meeting certain criteria and special application.
Please note that these *rates apply to **each** sponsored dependent* that you enroll. If you are enrolling more than one sponsored dependent, multiply the applicable rate by the total number of sponsored dependents to be covered to determine the total amount that will be deducted each pay for Sponsored Dependent Coverage.
Example: covering two non-Medicare-eligible sponsored dependents under Prime Care Advantage would result in:
– a **biweekly deduction** of $823.38 ($411.69 x 2) – a **monthly deduction** of $1,784.00 ($892 x 2)
for Sponsored Dependent Coverage, in addition to the rate you pay for covering yourself and any other dependents.