ADULT CHILD CERTIFICATION FOR EXTENDED COVERAGE

OME-RESA Health Benefits Program

IMPORTANT NOTICE REGARDING ELIGIBILTY RULES for ADULT CHILDREN

Dear Employee:

At your option and expense, you can extend coverage for your children under your health care plan in accordance with Ohio law. This coverage can be extended by you until the child reaches age 28, provided that the child is:

1) not married;
2) your natural child, stepchild or adopted child;
3) a resident of Ohio;
4) or, if not a resident of Ohio, a full time student at an accredited public or private institution of higher education;
5) not employed by an employer that offers any health care benefit plan under which the child is eligible for coverage; and
6) not eligible for coverage under Medicare or Medicaid.

Please note that this form must be signed by you, and the child for whom you seek extended coverage.

I hereby request extended coverage under my health care plan for my adult child as indicated below.

Plan Name _____ Plan Number _____

Employee's Name _____ Employee's S.S. No. _____

Employee's Full Address _____

Employee's Phone contact information _____

ADULT CHILD INFORMATION

Adult Child's Full Name _____ Gender _____ Social Security No. _____

Adult Child's Date of Birth _____ Relationship _____ Marital Status _____

Adult Child's Mailing Address _____

Adult Child's Phone Contact Information _____

Is this child employed? YES ☐ NO ☐ Is this adult child a full time student Yes ☐

If this adult child is a student, please attach to this application for coverage information regarding the student status of the individual.

Name and Address of Adult Child's Employer _____

Does this Employer offer any health insurance (health care benefits) for which the adult child is eligible? Yes ☐ No ☐

Requested Effective Date of Coverage (cannot be retroactive - documentation may be required) _____

SIGNATURE OF EMPLOYEE and CHILD

I hereby certify under penalties of fraud that all information provided on this form, and any attachment hereto, made by me is correct to the best of my knowledge, and authorize the release of any and all information necessary in connection with this request for extended coverage. I understand, that my employer may rescind this coverage at any time on the basis of any untrue, inaccurate or incomplete answers to any question in connection with this request for extended child coverage and may seek reimbursement for any claims paid in connection with this extension of coverage where such coverage was granted in connection with any false, misleading, or inaccurate information, including information deemed to be a misinterpretation, ommission or concealment of information by me or my child. I further understand that any coverage so extended in connection with this request shall be granted in full reliance on the statements made by me herein and in consideration of the information and answers provided hereinabove. It is also understood by the undersigned that failure to pay the premiums necessary to maintain this coverage shall result in its cancellation, and any such premiums required in connection with this extended coverage are subject to change from time to time.

_____ _____
Employee Signature Date

_____ _____
Signature of Child for Whom coverage is being requested Date

_____ _____
Signature of Employer Date

WARNING: Any person who, with intent to defraud or to knowingly deceive his employer with this request for extended coverage, submits an application, or files a false claim containing a false or deceptive statement or answer, is guilty of fraud. (Ohio Revised Code Section 3999.21) This also applies to anyone who knowingly fails to notify his or her employer of a change in circumstances that would otherwise disqualify an older age child from being eligible to continue extended coverage under this plan.