AFFIDAVIT OF DEPENDENCY FOR OHIO GROUP COVERAGE

Subscriber Name: _____ Group Name: Lawrence County Schools COG

Subscriber Identification Number: _____ Dependent Date of Birth: _____

Group Number: 00171454 Requested Effective Date: _____

- This affidavit should be executed, notarized and submitted if you are applying for coverage for an unmarried child who has reached the limiting age of the policy and is requesting either an extension or reinstatement of coverage until the end of the month in which the child reaches age 28.

I, _____ ("Subscriber") after being first duly sworn, depose and attest to the following:

- I am at least eighteen (18) years of age and I am mentally competent to contract;

- I am applying for coverage for _____(name), who is my unmarried _____(relationship);

- The unmarried child meets all of the following eligibility requirements:

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

- I understand that if this dependent ceases to be an eligible dependent, I am required to submit an Application for Change within 31 days of the termination of the dependency, and the coverage for the dependent will cease at the end of the period for which premiums or administrative fees have been paid.
- I understand that monthly Plan premiums will be adjusted by Anthem, as applicable, once the dependent is enrolled, to reflect the additional dependent coverage. Any additional premiums will included in the group billing and will not be calculated separately.
- I understand that I may be responsible for any increase in monthly group premium and that I am to discuss any questions regarding payment arrangements with my group contact.

Pursuant to federal law, health plans are required to continue coverage for students unable to attend a post secondary institution as a result of a medical leave of absence. If your dependent meets the requirements for a medical leave of absence, your dependent's coverage will be extended to the earlier of 12 months from the date the medical leave began or until the dependent is no longer eligible for your health plan coverage.

I certify, under penalty of perjury, that the foregoing is true and correct.

_____
Subscriber Signature

Signatures must be notarized.

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20___, before me personally appeared the above named _____, to me known to be the person described herein, and who executed the foregoing, and swore to its truth.

Before me, _____
Notary Public Signature and Commission Exp. Date

Anthem Use Only - DCN: _____

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