Extended Dependent Benefits Enrollment Form

Ohio University Employee:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Employee #</th>
</tr>
</thead>
</table>

Extended Dependent Child:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
</tr>
</thead>
</table>

Child’s Street Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

I certify that the child listed above is:

- Unmarried
- Not yet reached their 28th birthday
- Not employed by an employer that offers any health benefit plan under which this child is eligible
- Not eligible for coverage under Medicaid or Medicare

And either:

- [ ] A full-time student at an accredited institution of higher education (proof of enrollment must accompany this form)
- [ ] A resident of Ohio

OR

I understand that this enrollment includes medical and prescription coverage only and is provided with an additional fee. Federal tax implications may apply to children in the calendar year in which they turn 27.

Signature of Employee ____________________________________________ Date: __________

Typed Name: ______________________________________________________ Date: __________

Submit to Human Resources

169 West Union Street
Athens, OH 45701

benefits@ohio.edu

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