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**The Health Plan and THP  
Ohio House Bill 1  
Young Adult Dependent  
Attestation Form**

Please have your employees complete and submit the attestation along with a new enrollment form if enrolling a Young Adult Dependent (YAD) qualifying under the state unmarried young adult dependent coverage provision House Bill 1. New enrollment forms **are not required if** the dependent has been terminated from coverage within the past 31 days. For groups who use an electronic enrollment process, you will still need to submit the attestation prior to the YAD being enrolled.

**By signing this attestation, I agree to all of the following under this Contract:**

- This attestation certifies that no YAD over the limiting age is currently enrolled or will be enrolled under The Health Plan/THP (the Plan), as outlined in my plan material, unless my Group contract begins on or after 7/1/2010 and **all** of the following eligibility criteria are met:

The YAD is:

- under the age of 28; **and**
  - unmarried; **and**
  - my natural child, stepchild, or adopted child; **and**
  - a resident of Ohio or a full-time student at an accredited public or private institution of higher education (if coverage is HMO coverage and the YAD is **NOT** a full-time student, the YAD must live within the Plan's Enrollment/Service Area); **and**
  - not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; **and**
  - not eligible for coverage under any Medicare or Medicaid program.
- I will provide the Plan with recertification of continuing eligibility and/or support documentation to confirm eligibility if requested by the Plan. I understand that the Plan will automatically terminate any YADs from the coverage if response is not received within 60 calendar days from the date of the request.
  - I understand that coverage terminates when my YAD no longer meets the criteria specified above, but no later than the end of the month in which he/she reaches the age of 28.
  - I agree to notify my employer or benefits administrator immediately when my YAD no longer meets the criteria specified above and if the Plan provides benefits because of a failure to be notified, that I may be responsible for repayment of said paid benefits to the Plan.
  - I understand that, upon enrollment of my YAD, the Plan will calculate a separate premium which must be paid through my employer.
  - I understand that any monthly Plan premium increase may be my responsibility to pay, subject to my Group's policy, and that any questions about such arrangements are to be directed to my employer or benefits administrator.

**By signing this attestation, I understand** that knowingly furnishing incorrect or incomplete information or failing to notify The Health Plan/THP of changes in eligibility status may result in termination of membership of my coverage and all dependents' or the offending dependent's coverage, upon 15 days' written notice from The Health Plan/THP.



**Employer Name:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Young Adult Dependent Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
(Print)

**Name of Employee:** \_\_\_\_\_ **HP ID#:** \_\_\_\_\_  
(Print)

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud."