

City of Toledo
DEPARTMENT OF HUMAN RESOURCES



Dependent Child Work Verification Affidavit

Section A – To be completed by employee

Employee – print name _____

Phone Number _____

My dependent child is: Employed full-time Employed part-time Unemployed Self-employed Retired Disabled

I UNDERSTAND THAT ANY FALSE DECLARATION, MATERIAL OMISSION OF INFORMATION, MISREPRESENTATION OR FALSIFICATION ON ENROLLMENT APPLICATIONS AND ANY AND ALL DOCUMENTS RELATED TO AND SUBMITTED FOR CITY OF TOLEDO BENEFITS COVERAGE MAY CONSTITUTE FRAUD AND MAY RESULT IN THE LOSS OF BENEFITS, LOSS OF COBRA CONTINUATION COVERAGE AND/OR LOSS OF DOMESTIC PARTNER CONTINUATION COVERAGE FOR MYSELF, ANY SPOUSE, DOMESTIC PARTNER, CHILDREN OR OTHER DEPENDENTS, MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING, TERMINATION OF EMPLOYMENT UNDER CITY OF TOLEDO POLICY, APPLICABLE LAW AND/OR COLLECTIVE BARGAINING AGREEMENT AND MAY RESULT IN THE CITY OF TOLEDO PURSUING CRIMINAL CHARGES AGAINST ME. I AGREE THAT THE CITY OF TOLEDO MAY RECOVER DAMAGES FOR ALL LOSSES INCLUDING, BUT NOT LIMITED TO, PAID CLAIMS, PREMIUM COSTS AND REASONABLE ATTORNEY FEES INCURRED.

I CERTIFY THAT THE INFORMATION PROVIDED IN ALL PARTS OF THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE.

Signature of Employee _____

Date _____

Section B – To be completed by dependent child

I, _____ authorize my employer to release my healthcare plan coverage information and authorize the City of Toledo to determine my eligibility for health care coverage.

Signature of Dependent Child _____

Date _____

Section C – To be completed by dependent child's employer

1. Is the person named as the dependent child eligible for healthcare coverage?

No, please explain: _____

STOP, please sign and date the form below.

Yes, please continue.

2. Does the employee receive a stipend or other incentive(s) or compensation to not enroll in your healthcare plan?

No Yes, please explain: _____

3. Has the employee enrolled in the healthcare plan?

Yes, effective date: _____ Insurance Company: _____

Coverage Type: Employee Only Employee +1 Family

No, please indicate date coverage was waived or cancelled _____

Employer Name _____

Authorized Employer Name _____

Phone _____

Authorized Employer Signature _____

Title _____

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 a false or deceptive statement is guilty of insurance fraud. (ORC 3999.21)