Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888-864-8363
Fax: (614) 628–1777
www.op–f.org

DEPENDENT CHILD HEALTH CARE STIPEND ELIGIBILITY

(age 18-26)

Complete and return this form to the Ohio Police & Fire Pension Fund (OP&F) to potentially receive an additional stipend amount for an adult child between ages 18-26. The eligibility guidelines are:

- Must be natural or adopted child of the member;
- Can be married or unmarried; and
- Not employed or offered any type of health care through an employer or other retirement systems

In order for new dependents to become eligible or for current dependents to continue to have eligibility, you must complete this form. For new dependents these additional documents must be included with this form.

- A completed Health Care Stipend Eligibility form;
- A copy of the birth certificate;
- A copy of the Medicare/Medicaid card (if applicable); and
- Proof of a qualifying life event (if applicable).

If your child is incapacitated contact your health care provider for coverage options.

Section A: Member information

Member name: First, MI, Last, suffix (Jr. III, etc.)	Social Security Number (last 4 only) X X X - X X -
Street Address / Post office box	Home telephone
City, State, ZIP code	Alternate telephone
Email	

Section B: Eligible dependent child information

CHILD #1:

Name	Social Security number
Relationship (check one): ❑ Natural child ❑ Adopted	Date of Birth
Is the child eligible for health care through his/her employer? ❑ Yes ❑ No	
Is the child eligible for Medicaid or Medicare? ❑ Medicaid ❑ Medicare ❑ Neither	

Section B: Eligible dependent child information (continued)

CHILD #2:

Name

Social Security number

Relationship (check one): ❑ Natural child ❑ Adopted

Date of Birth

Is the child eligible for health care through his/her employer? ❑ Yes ❑ No

Is the child eligible for Medicaid or Medicare? ❑ Medicaid ❑ Medicare ❑ Neither

CHILD #3:

Name

Social Security number

Relationship (check one): ❑ Natural child ❑ Adopted

Date of Birth

Is the child eligible for health care through his/her employer? ❑ Yes ❑ No

Is the child eligible for Medicaid or Medicare? ❑ Medicaid ❑ Medicare ❑ Neither

Section C: Signature and acknowledgement

I, the person described in Section A of this *Dependent Child Health Care Stipend Eligibility* form, certify that all information provided by me is true and complete.

Member Signature: ▶

Date of signature:

Section D: Notary public requirement for member acknowledgement and signature

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Dependent Child Health Care Stipend Eligibility* form was acknowledged before me by the member named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here

Notary's signature: ▶

Print name:

My commission expires: