

Health Election *Medical, Dental, Vision*

SECTION I: PERSONAL INFORMATION

Employee's Full Name	First	M.I.	Last	OSU Employee ID Number
E-Mail Address			Daytime Phone Number	

SECTION II: REASON FOR COMPLETING FORM

Date of event: ____ / ____ / ____ (return form within 31 days of event date)

Qualifying status change (please specify)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hired/Newly Eligible | <input type="checkbox"/> Divorce/Dissolution ¹ | <input type="checkbox"/> Addition/Termination of Same-Sex Domestic Partner Coverage ² |
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Obtained Other Coverage ¹ | <input type="checkbox"/> Addition/Termination of Sponsored Dependent Coverage ² |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of Other Coverage ¹ | <input type="checkbox"/> Change in Dependent Eligibility ¹ |
| <input type="checkbox"/> Birth/Adoption/Legal Guardianship/Legal Custody ¹ | | |
| <input type="checkbox"/> Other ¹ (describe): _____ | | |

¹ Documentation may be required. ² Affidavit required.

SECTION III: HEALTH PLAN COVERAGE SELECTION

A. I elect medical coverage—make plan selection below:

<input type="checkbox"/> Prime Care Advantage ³	<input type="checkbox"/> Prime Advantage Value ³	<input type="checkbox"/> Prime Advantage Plus ³	<input type="checkbox"/> Independent Choice	<input type="checkbox"/> Out-of-Area Plan ⁴
--	---	--	---	--

Prime Care Connect—Special eligibility rules apply for enrollment in this plan, including eligible employment of at least one year. Application requires proof of qualifying household income. Refer to the Prime Care Connect Application Guide online at hr.osu.edu/benefits/hb_medical or in the Benefits Overview book. Contact OSU Health Plan at (614) 292-4700 or 1-800-678-6269 to apply. To ensure medical plan coverage, you are encouraged to elect one of the plans listed on this form. Once your eligibility for Prime Care Connect is verified, your enrollment will be automatically transferred to that plan.

³ Special application required for individual access to out-of-area coverage. ⁴ Premium at Prime Care Advantage rate; eligibility based on qualified zip code.

I waive medical coverage

B. I elect dental coverage I waive dental coverage

C. I elect vision coverage I waive vision coverage

SECTION IV-A: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Please list self and all eligible family members to whom new coverage or coverage changes will apply. (Use chart on reverse if additional space is needed.)

Please use the numbers and letters on reverse to indicate **Relationship to Employee**. Review dependent eligibility guidelines online at

hr.osu.edu/benefits/benefitseligibility.

Name	Relationship to Employee (use codes on reverse)	Birth Date:		Gender		Address different from employee? ⁵		Social Security Number (required)	Choose coverage for employee and each eligible dependent:								
		(mm/dd/yy)	Age	M	F	YES	NO		Medical		Dental		Vision				
									YES	NO	YES	NO	YES	NO			
Employee (named in SECTION I)	0																

⁵ If dependent's address differs from employee's address, provide dependent's address in **SECTION IV-B** on reverse.

SECTION V: AUTHORIZATION

I have received, read, and understand the material explaining the terms and conditions of The Ohio State University Health Plans. I declare that any individual for whom I am requesting health coverage meets the definition of an eligible dependent as stated in *Dependent Eligibility Guidelines*, online at hr.osu.edu/benefits/benefitseligibility.

I understand that any person who knowingly and with intent to defraud applies for coverage or files a claim containing any materially false information is guilty of fraud and is thereby subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year unless a qualifying status change occurs, as defined by the plan. The Office of Human Resources must receive notification on the appropriate form(s) within 31 days.

I understand that this salary redirection authorization of pre-tax premium contributions and, if applicable, post-tax contributions will remain in effect and are not revocable, except as noted above. I understand that Ohio State's contribution amount for medical and dental coverage for a same-sex domestic partner and his or her dependent(s) is considered imputed income and I will be taxed on that value.

I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature	Date
-----------	------

Return completed form to:

The Ohio State University, Office of Human Resources, Benefits Processing/Health, 1590 North High Street, Suite 300, Columbus, OH 43201-2190; Fax: (614) 292-7813

