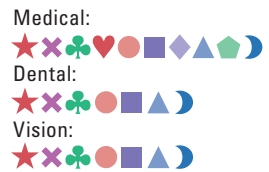


HEALTH Election Form Medical, Dental, Vision



SECTION I: PERSONAL INFORMATION

Employee's Full Name: First	M.I.	Last	OSU Employee ID # (required)
Address: Street	City/State	Zip	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"/> Birth/Adoption/Legal Guardianship ¹ | <input type="checkbox"/> Loss of Other Coverage ¹ | <input type="checkbox"/> Change in Dependent Eligibility ¹ |
| <input type="checkbox"/> Marriage | | |
| <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

Select your plan:

- Prime Care Advantage³
- Prime Advantage Value³
- Prime Advantage Plus³
- Independent Choice
- Out-of-Area Plan⁴

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; hr.osu.edu/benefits/eligibility.htm

I waive medical coverage—check reasons:

1. I certify that I currently have medical coverage through another plan

Choose one:

- My current plan is more affordable
- My current plan provides better coverage for medical situations important to me
- My current plan provides a broader network of providers
- I am covered as a dependent on Ohio State's medical plan through my spouse/partner
- Other—Comments: _____

2. I do not currently have other medical coverage

Choose one:

- My family income is not sufficient to pay for the employee contribution
- I don't expect to have a need for health care services at this time
- Other—Comments: _____

B. I elect dental coverage

- I waive dental coverage

C. I elect vision coverage

- I waive vision coverage

SECTION IV: Please complete EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION on page 2.

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*, available online at hr.osu.edu/hrpubs/ben/depeligibility.pdf.

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

HEALTH Election Form Medical, Dental, Vision

SECTION IV-A: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

(Please list self and all family members to whom new coverage or coverage changes will apply)

Name	Relationship to Employee (see list below)	Birth Date: (M/D/Y)	Gender		Address different from employee? ⁵		Social Security Number (required)	Choose coverage for employee and each eligible dependent:					
			M	F	YES	NO		Medical		Dental		Vision	
								YES	NO	YES	NO	YES	NO
Employee (named in SECTION I)	0												

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

Please use the following numbers and letters to indicate **Relationship to Employee**

- | | | |
|---|--|---|
| <p>0 Employee</p> <p>1 Spouse</p> <p>2 Same-Sex Domestic Partner
(Affidavit of Same-Sex Domestic Partnership for Health Care and Life Insurance Coverages required)</p> <p>3 Dependent Child (under age 23, unless fully disabled).
Please specify:</p> <p>3A Dependent Child of Employee</p> <p>3B Dependent Child of Employee's Spouse</p> <p>3C Dependent Child of Employee's Same-Sex Domestic Partner</p> | <p>4 Sponsored Dependent (rates for sponsored dependents differ from rates for other family members; Affidavit of Sponsored Dependency for Health Care Coverage required). Please specify:</p> <p>4A Parent, Step-Parent, Parent-in-Law, or person who stood in loco parentis to the employee as a child</p> <p>4B Grandparent or Grandparent-in-Law</p> <p>4C Sibling or Sibling-in-Law</p> <p>4D Aunt or Uncle</p> <p>4E Niece or Nephew</p> | <p>4F Son- or Daughter-in-Law</p> <p>4G Grandchild or Grandchild-in-Law</p> <p>4H Biological, Adopted, Step, or Foster Child who is not otherwise eligible for coverage under the terms of the university's group health plans</p> <p>4I Opposite-Sex Domestic Partner</p> <p>4J Dependent Child of Employee's Opposite-Sex Domestic Partner</p> |
|---|--|---|

SECTION IV-B: DEPENDENT ADDRESS INFORMATION (if different from employee's address)

If you indicated in SECTION IV-A that any dependent's address differs from the employee's address, please provide that dependent's name and mailing address below:

Dependent's Name _____

Street Address _____

City _____ State _____ Zip _____

Dependent's Name _____

Street Address _____

City _____ State _____ Zip _____

If you have questions, contact the Office of Human Resources Customer Service Center: E-mail: service@hr.osu.edu
 Internet: hr.osu.edu
 Phone: (614) 292-1050 or 1-800-678-6010

Return completed form to: Office of Human Resources, Benefits Processing, 1590 North High Street, Suite 300, Columbus, OH 43201-2190; Fax: (614) 292-7813