Office of HUMAN RESOURCES | THE OHIO STATE UNIVERSITY

Application for Continued Health Plan Eligibility for Over Age Dependents

For dependents over the age of 26 who are incapable of self-sustaining employment by reason a physical or mental disability or impairment and are primarily dependent on the employee for support.

To be completed by employee

Dependent Child's Name (Last, First, Middle Initial) ______________________________

☐ Male ☐ Female Dependent's birth date ____________ Relationship to Employee ____________

Employee Name ______________________ OSU Employee ID # ____________

NGS Member ID # (from OSU medical card) ______________________________

Employee Address

Street ______________________________

City ____________ State ____________ Zip ____________

Dependent's Marital Status

☐ Single ☐ Married ☐ Other ____________ Date of Dependent's Disability ____________

Is this dependent residing in your household?

☐ Yes ☐ No If no, explain: ______________________________

Do you provide more than half of this dependent's support?

☐ Yes ☐ No If yes, % of total: ______________________________

Please return this application with the enclosed physician statement completed by the dependent's attending physician. If your dependent has received an Award of Social Security Disability Benefits, you may submit it with your completed questionnaire instead of the physician statement.

Verification of dependent eligibility will be requested periodically.

I understand that, as an Ohio State health plan member, I have the responsibility to provide when requested complete and factual information to the Office of Human Resources relating to dependency verification as specified in the Medical Plan Specific Plan Details outlining program provisions for the university's health plans. I further 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, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

I certify that all information provided on this form is true and correct to the best of my knowledge and understand that it is my responsibility to notify the Office of Human Resources within 31 days of a change is dependent status.

Signature of faculty/staff member: ______________________________ Date: ____________

Mail your response to:
OSU Health Plan
Attention: Lorena Owings
700 Ackerman Road, Suite 440
Columbus, OH 43202

For office use only
Does the dependent qualify as disabled under the medical plan? ☐Yes ☐No
If yes, date of next re-certification:
Date Office of Human Resources was notified to continue coverage:

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Physician Statement of Disability for Continued Health Plan Eligibility

Date__________________ Employee Name ____

OSU Employee ID # ______________________________ NGS Member ID # ______________________
(from OSU medical card)

Employee Address

Street ____

City ____________________________ State ____________________________ Zip ______________

Dependent/Patient Name ____

Please respond to the questions below as completely as possible. This information will assist OSU Managed Health Care Systems, Inc. in determining this patient's continued eligibility for Ohio State's health plan as a covered dependent.

Physician Information

Physician Name ____

Specialty ________________________________ License Number ______________________________

Address ____

Telephone Number ______________________________ Fax Number ______________________________

Diagnosis(es) (ICD-9) ____

1. How long have you treated this patient, and when did you last see him/her?

____

____

2. What is the degree and impact of the physical/mental impairment?

	Percentage of Impairment			
Please check one box on each line	25%	50%	75%	100%
Activities of Daily Living (ADL)............	☐	☐	☐	☐
Mobility..	☐	☐	☐	☐
Cognitive..	☐	☐	☐	☐
Social Skills..	☐	☐	☐	☐
Language/Communication	☐	☐	☐	☐

3. Is this patient incapable of self-sustaining employment by reason of mental and physical impairment/disability? ☐Yes ☐No
If yes, please explain. ____

____

4. What is the date this dependent initially became incapable of self-sustaining employment?______________________

5. Might this patient be capable of self-sustaining employment in the future? ☐Yes ☐No
If yes, please provide approximate time frame. ____

Physician's signature: ____ Date: ________________

Physician's printed name: ____

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