



Dependent Group Term Life Insurance (DGLI) Election Form

If you are currently in an eligible enrollment period for dependent group term life insurance (DGLI) coverage, you have 31 days from the qualifying event date to submit your election form to enroll dependents. Enrollment at any other time requires medical Evidence of Insurability (EOI). Submit appropriate documentation with this form, if applicable.

SECTION I: PERSONAL INFORMATION (print or type)

Faculty/Staff Member's Full Name:

First M.I. Last OSU Employee ID Number

Social Security Number (optional) Birth Date Daytime Phone Number

E-mail Address

SECTION II: DGLI ELECTION

- I wish to elect the following DGLI coverage level: (select one)
- Plan 1:** \$2.00 per month premium; provides \$5,000 for spouse/same-sex domestic partner and \$2,500 for each eligible dependent child
- Plan 2:** \$4.00 per month premium; provides \$10,000 for spouse/same-sex domestic partner and \$5,000 for each eligible dependent child
- Plan 3:** \$6.00 per month premium; provides \$10,000 for spouse/same-sex domestic partner and \$10,000 for each eligible dependent child
- Change coverage due to:**

(Coverage change effective first of month following receipt of form, or date determined by Anthem Life)

- Hired/Newly Eligible, *date of event:* _____
- Marriage/Establishment of a same-sex domestic partnership¹, *date of event:* _____
- Divorce/Termination of same-sex domestic partnership¹, *date of event:* _____
- Birth/Adoption, *date of event:* _____
- Change in dependent eligibility, *date of event:* _____
- Other², please specify: _____, *date of event:* _____

- Terminate/Decline Coverage

¹ Affidavit of Same-Sex Domestic Partnership For Health Care and Life Insurance Coverages is required.

² Medical Evidence of Insurability (EOI) may be required.

SECTION III: SAME-SEX DOMESTIC PARTNER COVERAGE ELECTION

If you are applying for DGLI coverage for your same-sex domestic partner, please complete the Affidavit of Same-Sex Domestic Partnership for Health Care and Life Insurance Coverages on the back of this form.

SECTION IV: DGLI PROGRAM PROVISIONS

The DGLI benefit pays the employee upon the death of an eligible dependent. Dependents are insured on the employee's effective date of coverage subject to the provisions of the group policy. The term "dependent" is limited to the employee's spouse, declared same-sex domestic partner, and eligible dependent children. Dependent eligibility, including age limitations, is further defined in the certificate of insurance and Life Insurance—Specific Plan Details document available online at hr.osu.edu/benefits/lifeinsdgli.htm. I hereby enroll for the insurance to which I am now entitled or to which I may become entitled under the provisions of the group policy or policies (including any future amendments) issued by Anthem Life Insurance Company on the employees of The Ohio State University and its designated affiliates. I authorize my employer to take deductions from my earnings sufficient to pay for the coverages I have elected. 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, including claiming persons who are not legal dependents or a domestic partner as indicated below, is guilty of insurance fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

SECTION V: AUTHORIZATION

I hereby apply for dependent group term life insurance and certify that I agree to the provisions stated on this form.

Signature of Faculty/Staff Member Date

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

Return completed form to: Office of Human Resources, Benefits Processing/Life, 1590 N. High St., Suite 300, Columbus, OH 43201-2190

For OHR use only: _____ Biweekly _____ Monthly Date Employed: _____



Affidavit of Same-Sex Domestic Partnership

(For Health Care and Life Insurance Coverages)

This form is to be completed when applying for health and/or life benefits for your eligible same-sex domestic partner. Return the completed Affidavit along with the applicable benefit election form(s) to the Office of Human Resources.

I, _____, and _____
Faculty/Staff Member (print) Same-Sex Domestic Partner (print)

OSU Employee ID Number OSU Employee ID Number

certify that **all** of the following are true:

1. We share a permanent residence (unless residing in different cities, states, or countries on a temporary basis).
 2. We are each other's sole same-sex domestic partner, have been in this relationship for at least six (6) months, and intend to remain in this relationship indefinitely.
 3. We are of the same sex as each other and neither of us is currently married to or legally separated from another person under either statutory or common law.
 4. We are responsible for each other's common welfare.
 5. We are at least eighteen (18) years of age and mentally competent to consent to this contract.
 6. We are not related by blood to a degree of closeness that would prohibit marriage in the state in which we legally reside.
 7. We are financially interdependent on each other in accordance with the plan requirements outlined by Ohio State. Financial interdependency may be demonstrated by the existence of three (3) of the following. (Please check below the documents that can and will be provided to the Office of Human Resources, if requested, to verify same-sex domestic partnership):
 - Joint ownership of real estate property or joint tenancy on a residential lease
 - Joint ownership of an automobile
 - Joint bank or credit account
 - Joint liabilities (e.g., credit cards or loans)
 - A will designating the same-sex domestic partner as primary beneficiary
 - A retirement plan or life insurance policy beneficiary designation form designating the same-sex domestic partner as primary beneficiary
 - A durable power of attorney signed to the effect that we have granted powers to one another
- I agree to file an Affidavit of Termination of Same-Sex Domestic Partnership with the Office of Human Resources and mail a signed copy to my previous same-sex domestic partner within 31 days of either of the following events:
 - There is any change in the circumstances attested to in this Affidavit that would make my same-sex domestic partner ineligible for coverage under the terms of the university's health and life insurance plans
 - We terminate our same-sex domestic partnership
 - I understand that another Affidavit of Same-Sex Domestic Partnership cannot be filed for at least six (6) months from the date that an Affidavit of Termination of Same-Sex Domestic Partnership is filed with the Office of Human Resources.
 - We provide this information to be used by the university for the purpose of determining our eligibility for benefits and for the administration of these benefits; we understand that the university will take reasonable steps to limit access to this information.
 - We understand that, by signing this Affidavit and as a result of Ohio State providing benefits to us, there may be legal and tax implications; therefore, we have been advised to consult with a legal/tax advisor regarding these implications.
 - We certify that the information provided in all parts of this Affidavit is true, accurate, and complete. We understand that a false declaration of same-sex domestic partnership, material omission of information on this Affidavit, or failure to timely inform Ohio State of the termination of a same-sex domestic partnership is considered fraud and may result in disciplinary action of an employee up to and including termination of benefits and/or employment. We also agree that Ohio State may recover damages for all losses (including paid claims and premium costs) and reasonable attorneys' fees incurred to recover such damages.

Signature of Faculty/Staff Member Date of Birth Date

Signature of Same-Sex Domestic Partner Date of Birth Date

Sworn to and subscribed in my presence this _____ day of _____
Date Month Year

(Seal)

Signature of Notary Public

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