

Section I: Personal Information

Name: Last _____ First _____ MI _____ OSU Employee ID Number _____

Address: Street _____ City _____ Zip Code _____

E-mail Address _____ Daytime Phone # _____

Section II: Medical Coverage Election

- Prime Care Advantage Health Plan (coverage does not include dental or vision benefits)
- Out-of-Area Plan¹ (coverage does not include dental or vision benefits)
- Waive/Cancel Coverage—no coverage desired
- Change in Coverage due to a Qualifying Family Status Change:

Event _____ Date of Event _____

¹Eligibility based on home zip code.

Section III: Please list all eligible dependents to be covered and provide the appropriate information.

Relationship to Applicant	Name	Social Security #	Birthdate	Gender
Applicant				

Section IV: Authorization

I have received, read, and understand printed material explaining The Ohio State University Health Plans. I declare that the dependents listed on this form meet the eligibility requirements of a qualifying dependent or domestic partner as stated in the Benefits Overview—Graduate Associates document, available online at hr.osu.edu/hrpubs/pubmenu.htm. I understand that any person who, with intent to defraud or knowing that he or she 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, is guilty of insurance fraud, which is 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 (September 12, 2007–September 11, 2008) unless a qualifying status change occurs, as defined by federal regulations. The Office of Human Resources must receive notification of the change within 31 days. I understand that this salary redirection authorization of pre-tax and/or post-tax premium contributions will remain in effect and is not revocable, except as noted above. I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature of Applicant _____ Date _____

For additional information, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, hr.osu.edu, (614) 292-1050, 1-800-678-6010, or fax (614) 292-6235.

Return within 31 days of eligible appointment date to: Office of Human Resources, Benefits Processing/Health, Suite 300, 1590 North High Street, Columbus, OH 43201-2190.