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 of a physical or mental disability or impairment and are primarily dependent on the employee for support.

SECTION 1: DEPENDENT INFORMATION (to be completed by employee)

Dependent Child's Full Name: First _____ M.I. _____ Last _____ Date of Birth _____

Relationship to Employee _____ Date of Dependent's Disability _____ ☐ Male ☐ Female

Dependent's Marital Status: ☐ Single ☐ Married ☐ Other: _____

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, percent of total: _____

SECTION 2: EMPLOYEE INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ OSU Employee ID# (required) _____

Home Mailing Address: Street _____ City _____ State _____ Zip Code _____

NGS Member ID# (from OSU medical card) _____ Phone _____ Email Address _____

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.

Note: Verification of dependent eligibility will be requested periodically.

SECTION 3: AUTHORIZATION

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 in dependent status.

Employee Signature _____ Date _____

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

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: _____

THE OHIO STATE UNIVERSITY

Physician Statement of Disability for Continued Health Plan Eligibility

SECTION 1: EMPLOYEE INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ Date _____

OSU Employee ID# (required) _____ NGS Member ID# (from OSU medical card) _____

Home Mailing Address: Street _____ City _____ State _____ Zip Code _____

Dependent/Patient's Full Name: First _____ M.I. _____ Last _____

SECTION 2: PHYSICIAN INFORMATION

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's Name: First _____ M.I. _____ Last _____ Specialty _____

License# _____ Telephone _____ Fax _____

Address: Street _____ City _____ State _____ Zip Code _____

SECTION 3: PATIENT INFORMATION

Diagnosis(es) (ICD-10): _____

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? (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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