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 I: 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 II: EMPLOYEE INFORMATION

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

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

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 III: 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 30 days of a change in dependent status.

Employee Signature | Date

Mail your response to:
OSU Health Plan, 700 Ackerman Road, Suite 1007, Columbus, OH 43202
Attention: Clinical Operations

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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

SECTION I: EMPLOYEE INFORMATION

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

OSU Employee ID# (required) | Member ID# (from OSU medical card)

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

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

SECTION II: EMPLOYEE INFORMATION

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

Physician's Name: First | M.I. | Last | Speciality

License# | Telephone | Fax

Address: Street | City | State | Zip Code

SECTION III: 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/Communications	☐	☐	☐	☐

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

Mail your response to:
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Attention: Clinical Operations