THE OHIO STATE UNIVERSITY

Office of Human Resources
Benefits
The Ohio State University
1590 N. High St., Suite 300
Columbus, OH 43201

At the request of the Office of Human Resources with The Ohio State University, we are sending this letter to gather information about any other medical plan coverage you and/or your dependent(s) may have. You can expect to receive this request for information from us annually, as coverage situations change and we need to ensure our records are updated accordingly. The coverage information that you provide allows us to properly determine benefit payments under the university's medical plan Coordination of Benefit rules.

Please provide the information listed in the enclosed Request for Additional Coverage Information to CoreSource within 15 days. This information can be provided to CoreSource via:

The CoreSource self-service website www.mycoresource.com. Once you have signed in, click on the link "Change Coordination of Benefits (COB)" on the home page; or

Phone at: 1-877-647-0083, ext. 83004; or

Fax at: 1-586-226-3111; or

Mail at: CoreSource
P.O. Box 2310
Mt. Clemens, MI. 48046

It is important that you respond to this request, even if you and/or your covered dependents do not have additional coverage, to ensure your claims can be processed in a timely and accurate manner.

If you should have any questions, contact Eligibility Services with CoreSource at 1-877-647-0083 EXT. 83004.

Enclosures

COB004R

Request for Additional Coverage Information

Please provide the following information for any other medical plan under which you and/or your dependents are covered.
IF NO OTHER COVERAGE EXISTS, PLEASE PROVIDE ONLY ITEMS #1-#3.

1. OSU Employee's Name:

2. CoreSource Employee's Unique Identifier Number:

3. Name of Other Insurance Provider (if none, write "Not Applicable", then sign and date the 2nd page of this form):

   ____

4. Other Insurance Provider's Address: ______________________________

   ____

5. Policy/Plan Number: ______________________________

6. Effective Date of Other Coverage: ______________________________

7. Names of individual(s) covered by the above plan and also covered by an Ohio State medical plan:

   ____________________ ____________________

   ____________________ ____________________

   ____________________ ____________________

   ____________________ ____________________

8. Coverage (named in #3) is provided by: (check only one)
   a. ______ OSU Employee's Previous Employer (COBRA)
   b. ______ Spouse's Current Employer
   c. ______ Spouse's Previous Employer (COBRA)
   d. ______ OSU Employee's Ex-Spouse
   e. ______ Spouse's Ex-Spouse
   f. ______ Medicare
   g. ______ CHAMPUS, Medicaid or other Government Plan

9. Name of Policyholder (for coverage named in #3): ______________________________

10. Policyholder's Social Security Number or Plan Member/ID Number:

    ____

11. Policyholder's Date of Birth:

    ____

(Continued on the reverse side)

Complete items #12-14 ONLY if you indicated in #8(d) that your dependent child(ren) have medical coverage through a former spouse.

12. Does a divorce decree or child custody agreement establish which parent is responsible for providing medical coverage? YES ______ NO ______

13. If yes, who is the parent responsible for providing primary coverage? ___________

____

14. If no, who has primary custody of the dependent children?

____

Complete item #15 ONLY if you indicated in #8(f) that other coverage is provided through Medicare.

15. Name of Individual with Medicare Coverage: ____________________

Effective Date of Medicare Coverage: ____________________

Eligibility Reason:

Age ________
Disability ________
Renal Disease ________

Name of Individual with Medicare Coverage: ____________________

Effective Date of Medicare Coverage: ____________________

Eligibility Reason:

Age ________
Disability ________
Renal Disease ________

I understand that, as an Ohio State medical plan member, I have the responsibility to provide, when requested, complete and factual information to CoreSource about any other medical coverage or insurance benefits that I may have, as specified in the Medical Plan Detail Document outlining program provisions for the university's medical 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.

______________________________ Employee's Signature

______________ Date

Thank you for completing this Request for Additional Coverage Information.

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