THE OHIO STATE UNIVERSITY

Health Election *Medical*

SECTION 1: PERSONAL INFORMATION

Employee's Full Name First M.I. Last OSU Employee ID Number

Email Address Daytime Phone Number

SECTION 2: REASON FOR COMPLETING FORM

Date of event: _____ /_____ / _____ (return form within 31 days of event date or by annual open enrollment deadline)

Qualifying status change (please specify)

- ☐ Hired/Newly Eligible
- ☐ Open Enrollment
- ☐ Birth/Adoption/Legal Guardianship[1]
- ☐ Marriage
- ☐ Divorce/Dissolution[1]
- ☐ Obtained Other Coverage[1]
- ☐ Loss of Other Coverage[1]
- ☐ Addition/Termination of Same-Sex Domestic Partner Coverage[2]
- ☐ Termination of Sponsored Dependent Coverage[2]
- ☐ Change in Dependent Eligibility[1]
- ☐ Other[1] (describe): _____

[1] Documentation may be required. [2] Affidavit required.

SECTION 3: HEALTH PLAN COVERAGE SELECTION

A. ☐ **I elect medical coverage**—make plan selection below:

☐ **Prime Care Advantage**[1] ☐ **Prime Care Choice**[1] ☐ **Out-of-Area Plan**[2]

[3] Special application required for individual access to out-of-area coverage. [4] Premium at Prime Care Advantage rate; eligibility based on qualified zip code.

☐ **I waive medical coverage**

SECTION 4: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Please list self and all family members to whom new coverage or coverage changes will apply. (Use chart on reverse if additional space is needed.) Please use the numbers and letters on reverse to indicate **Relationship to Employee.** Review dependent eligibility guidelines online at **hr.osu.edu/benefits/benefitseligibility.aspx.**

Name	Relationship to Employee (use codes on reverse)	Birth Date (mm/dd/yy)	Age	Gender M	Gender F	Address different from employee?[5] YES	Address different from employee?[5] NO	Social Security Number (required)	Choose medical coverage for employee and each eligible dependent: YES	Choose medical coverage for employee and each eligible dependent: NO
Employee (named in SECTION I)	**0**									

[5] If dependent's address differs from employee's address, provide dependent's address in **SECTION 6** on reverse.

SECTION 5: AUTHORIZATION

I have read, understand and agree to the terms and conditions of The Ohio State University Faculty and Staff Health Plans. I declare that any individual for whom I am requesting health coverage meets the definition of an eligible dependent as stated in the Dependent Eligibility Guidelines, available online at **hr.osu.edu/benefits/benefitseligibility.aspx**. I understand that the university has the ability to rescind coverage if such coverage was gained due to an individual (or person seeking coverage on behalf of an individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact. I understand that any person who applies for coverage or files a claim containing any materially false information may be 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 unless a qualifying status change occurs, as defined by the applicable plan, and the Office of Human Resources receives timely notification of such change as provided under the applicable plan. I authorize the university to deduct from my pay any pre-tax contributions and/ or after-tax contributions described in the premium rate charts online at **hr.osu.edu/benefits/hb_rates**. I understand that this salary deduction authorization of pre-tax premium contributions and, if applicable, after-tax contributions will remain in effect and is not revocable, except as described in the applicable plan. I understand that Ohio State's contribution amount for medical, vision and dental coverage for a same-sex domestic partner and his or her dependent(s) is considered imputed income and I will be taxed on that value, unless my same-sex domestic partner and/or his or her dependent(s) are my tax dependents under Section 152 of the Internal Revenue Code. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for these benefits or I go on an unpaid leave of absence, I will be billed directly for these contributions. I agree to pay those employee contributions promptly and in full. If employee contributions are not paid in full, the benefits will be terminated for lack of payment and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature Date

THE OHIO STATE UNIVERSITY

SECTION 4 (CONTINUED): ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Please list additional family members to whom new coverage or coverage changes will apply.

Name	**Relation-ship to Employee** (see list below)	Birth Date **(mm/dd/yy)**	**Age**	Gender **M**	**F**	Address different from employee?[5] **YES**	**NO**	Social Security Number (required)	Choose medical coverage for employee and each eligible dependent: **YES**	**NO**

[5]If dependent's address differs from employee's address, provide dependent's address in **SECTION 6** below.

Please use the following numbers and letters to indicate **Relationship to Employee.** Review dependent eligibility guidelines online at **hr.osu.edu/benefits/benefitseligibility**.

0 Employee
1 Spouse
2 Same-Sex Domestic Partner (*Affidavit of Same-Sex Domestic Partnership for Benefit Coverage* required)
3 Dependent Child (under age 26, unless fully disabled). Please specify:
3A Dependent Child of Employee
3B Dependent Child of Employee's Spouse
3C Dependent Child of Employee's Same-Sex Domestic Partner

After you have enrolled your eligible dependents, a dependent verification packet will be mailed to your home address. All health plan members must provide proof of each covered dependent's eligibility. Required documentation will include applicable information from recent federal tax return, copies of birth certificates, marriage certificates, affidavits of same-sex domestic partnership, proof of joint ownership, etc. Failure to provide required documentation will result in coverage termination for the dependent(s) not verified.

SECTION 6: DEPENDENT ADDRESS INFORMATION (if different from employee's address)

If you indicated in SECTION 4 that any dependent's address differs from the employee's address, please provide that dependent's name and mailing address below:

Dependent's Name

Street Address

City State Zip

Dependent's Name

Street Address

City State Zip

If you have questions, contact the Office of Human Resources Customer Service Center:
Email: hr-Customer_Service@osu.edu • **hr.osu.edu** • Phone: 614-292-1050 or 800-678-6010

Return completed form to: Office of Human Resources, Benefits Processing,
1590 North High Street, Suite 300, Columbus, OH 43201-2190; Fax: 614-292-7813