THE OHIO STATE UNIVERSITY

Health Election *Medical, Dental, Vision*

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** ☐ **Prime Care Choice** ☐ **Out of Area Plan**[3, 4]

Prime Care Connect—Special eligibility rules apply for enrollment in this plan. Application requires proof of qualifying household income. Refer to the Prime Care Connect Application Guide online at **go.osu.edu/oe-connect-guide** or in the Benefits Overview book. Contact OSU Health Plan at 614-292-4700 or 800-678-6269 to apply. **To ensure medical plan coverage, you are encouraged to elect one of the plans listed on this form. If your eligibility for Prime Care Connect is verified, your enrollment will be automatically transferred to that plan.**

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

☐ **I waive medical coverage**

B. ☐ I elect dental coverage ☐ I waive dental coverage
Dental coverage level: ☐ Employee only ☐ Employee + Children ☐ Employee + Spouse ☐ Family

C. ☐ I elect Basic vision coverage ☐ I elect Premier vision coverage ☐ I waive vision coverage
Vision coverage level: ☐ Employee only ☐ Employee + Children ☐ Employee + Spouse ☐ Family

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 **go.osu.edu/dep-eligibility**.

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 coverage for employee and each eligible dependent: Medical YES	Medical NO	Dental YES	Dental NO	Vision YES	Vision 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 **go.osu.edu/dep-eligibility**. 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/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

Employee Name _____ Employee ID# _____

SECTION 4 (CONTINUED): ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

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

Name	Relationship to Employee (see list below)	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 coverage for each eligible dependent: Medical YES	Medical NO	Dental YES	Dental NO	Vision YES	Vision NO

Please use the following numbers and letters to indicate **Relationship to Employee.** Review dependent eligibility guidelines online at **go.osu.edu/dep-eligibility**.

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

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 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@osu.edu • Internet: **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