

Access to out-of-area coverage is available with this special application to individuals enrolled in Prime Care Advantage, Prime Care Choice or Prime Care Connect who will reside outside Ohio for at least 30 consecutive days. Benefits for medical services received outside Ohio while on approved out-of-area coverage will be paid in accordance with the Out-of-Area Plan or Basic Out-of-Area Plan. Applications must be renewed annually.

NOTE: When seeking care outside Ohio or the United States, use Ohio State Travel Assistance services.

SECTION 1: PERSONAL INFORMATION

Employee's Full Name: First	M.I.	Last	OSU Employee ID# (required)
Daytime Phone Number	Email Address		

SECTION 2: REASON FOR COMPLETING FORM¹

Effective date of Out-of-Area Benefit: Beginning Date: _____ Ending Date: _____

- 1. Faculty on sabbatical
- 2. Faculty/Staff on off-duty term
- 3. Faculty/Staff on approved leave of absence
- 4. Dependent child living with a primary guardian who lives outside Ohio

Name of Legal Guardian: First	M.I.	Last	Relationship to Employee
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- 5. Dependent attending college outside the area

Name of School	Location of School
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- 6. Other, please specify: _____

Mailing Address: Street	City	State	Zip
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¹An extension must be filed if outside the area after the end date.

SECTION 3: ENROLLEE INFORMATION (Name of person(s) applying for Out-of-Area Benefit)

Enrollee Name	Social Security Number	Birthdate	Gender	Reason#	Relationship

SECTION 4: CERTIFICATION

I certify that the above named individuals will reside outside of Ohio for 30 consecutive days or more and meet the stated eligibility requirements for enrollment in the Out-of-Area Benefit. I realize that once the covered individuals return to visit or for permanent residency in the area, they may be required to utilize network facilities. I understand that my elections may not be changed during the plan year unless a qualifying status change occurs, as defined by federal regulations. I also understand that if a qualifying status change occurs, I must complete a Health Election Form within 31 days of the event (available online at hr.osu.edu/forms).

I certify that all information provided on this form is true and correct to the best of my knowledge. I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, including claiming persons who are not legal dependents, is guilty of insurance fraud.

Signature of Applicant	Date
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If you have additional questions, contact the Office of Human Resources Customer Service Center at:
HR@osu.edu, 614-292-1050 or 800-678-6010.

Return completed form to: The Ohio State University, Office of Human Resources, Benefits Processing,
 1590 North High Street, Suite 300, Columbus, OH 43201-2190, or fax to: 614-292-7813.