THE OHIO STATE UNIVERSITY

Out-of-Area Benefit
Election Form

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 except for Prime Care Connect. Applications must be renewed annually.

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

SECTION I: PERSONAL INFORMATION

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

Daytime Phone Number _____ Email Address _____

SECTION 2: REASON FOR COMPLETING FORM[1]

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 _____

- ☐ 5. Dependent attending college outside the area

Name of School _____ Location of School _____

- ☐ 6. Other, please specify: _____

Mailing Address: Street _____ City _____ State _____ Zip _____

[1]An extension must be filed if outside the area after the end date.

SECTION 3: EMPLOYEE AND/OR ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Enrollee Name	Birth Date	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/policies-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 _____

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**.