THE OHIO STATE UNIVERSITY

Out-of-Area
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 be living in a qualifying ZIP code (i.e., outside the network area) for at least 30 consecutive days. To determine if a zip code qualifies see "Plan Eligibility by Zip Code" at **hr.osu.edu/benefits/medical**. Benefits for medical services received while on approved out-of-area coverage will be paid in accordance with the Out-of-Area except for Prime Care Connect. Applications must be renewed annually. If the Out-of-Area Benefit Election Form is received in our office within 30 days of the event (i.e., newly benefits eligible or the date the covered person moved outside the network area), Out-of-Area benefits will be effective on the event date. If the form is received after 30 days of the event, Out-of-Area benefits will be effective on the date the form is received in our office. Applications must be renewed annually. **NOTE:** When seeking care outside Ohio or the United States, use Ohio State Travel Assistance services. For more information go to: **hr.osu.edu/benefits/travel-assistance**.

SECTION I: PERSONAL INFORMATION

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

Daytime Phone Number Email Address

SECTION 2: EVENT AND MAILING ADDRESS

☐ New Hire/Newly Eligible Date: _____

☐ Covered Person Moved Outside the Network Area Date: _____

Mailing Address: Street City State Zip

NOTE: Mailing address must be outside of Ohio, or meet the Plan Eligibility by Zip Code criteria.

SECTION 3: ELIGIBILITY END DATE

Termination of Eligibility/Annual Renewal **Date**

SECTION 4: ENROLLEE INFORMATION

Enrollee Name	Birth Date

SECTION 5: CERTIFICATION

I have read and understand the materials describing the terms and conditions of The Ohio State University Faculty and Staff Health Plan Out of Area option and agree to such terms and conditions. I declare that any individual for whom I am requesting health coverage as my dependent meets the definition of an eligible dependent as stated in the Dependent Eligibility Guidelines, available online at **hr.osu.edu/benefits/dependent-eligibility-guidelines**. I further declare that any individual for whom I am requesting coverage under the Out of Area option will reside in a qualifying ZIP code for 30 consecutive days or more. I understand and agree that covered individuals may be required to utilize network facilities when located within the network area. I understand that the university has the ability to rescind (i.e., retroactively terminate) 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 canceled at any time during the plan year (ending December 31) 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, on a pre-tax or after tax basis, as the case may be, the applicable employee contributions described in the benefit plan rates online at **hr.osu.edu/benefits/rates**. I understand that this authorization to deduct employee contributions directly from my pay (i.e., a salary redirection arrangement) will remain in effect during the period of coverage and is not revocable, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, 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 of Applicant Date

For additional information or to submit your form electronically, contact HR Connection at **hrconnection.osu.edu**, **(614)247-myHR (6947)** or **HRConnection@osu.edu**. Representatives are available Monday-Friday, 8 a.m. – 5 p.m.
If you print a hard copy, 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**.