THE OHIO STATE UNIVERSITY

COBRA Open Enrollment Form
Health Election for Medical, Dental, Vision

Use this form to change your health elections or drop health coverage effective January 1, 2025.

SECTION I: PERSONAL INFORMATION

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

Address, Street | City/State | Zip | Daytime Phone Number

COBRA Enrollee's Full Name: First | M.I. | Last | Social Security # (required)

SECTION 2: REASON FOR COMPLETING FORM

Open Enrollment—**Form due Nov. 20, 2024**
Note: COBRA coverage begins after the first payment is received by Luminare and is retroactive to the date of the qualifying event.

SECTION 3: HEALTH PLAN COVERAGE SELECTION

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

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

☐ **I waive medical coverage**

Medical coverage level:
☐ Employee only ☐ Employee + Spouse
☐ Employee + Children ☐ Family

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

[1] Premium at Prime Care Advantage rate; eligibility based on qualified zip code. To determine if your zip code qualifies for the Out-of-Area Plan visit **hr.osu.edu/benefits/medical**.

B. ☐ **I elect dental coverage**—make selection below:

☐ Dental Basic ☐ Dental Plus

☐ **I waive dental coverage**

Dental coverage level:
☐ Employee only ☐ Employee + Spouse
☐ Employee + Children ☐ Family

C. ☐ **I elect vision coverage**—make selection below:

☐ Vision Basic ☐ Vision Plus

☐ **I waive vision coverage**

Vision coverage level:
☐ Employee only ☐ Employee + Spouse
☐ Employee + Children ☐ Family

SECTION 4-A: ENROLLEE INFORMATION

Please list self (employee) and/or eligible enrollees (dependents) who are enrolling in COBRA coverage.
Note: The employee is not required to enroll in COBRA benefits if electing coverage only for dependents.

Name	**Relationship to Employee** (see list below)	Birth Date	Gender		Address different from employee?[2]		Social Security Number (required)	Choose coverage for each eligible dependent					
								Medical		**Dental**		**Vision**	
		MM/DD/YYYY	**M**	**F**	**YES**	**NO**		**YES**	**NO**	**YES**	**NO**	**YES**	**NO**

Add additional dependents on reverse

[2] If dependent's address differs from employee's address, provide dependent's address in **SECTION 4-C**.

Please use the following numbers and letters to indicate

Relationship Code
0 Employee
1 Spouse
2 Dependent Child – please specify:
2A Dependent Child of Employee
2B Dependent Child of Employee's Spouse

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, The Ohio State University Faculty and Staff Vision Plan, and The Ohio State University Faculty and Staff Dental Plan (together, the "health plans"), and agree to such terms and conditions. I wish to continue coverage under the health plans in accordance with my above elections. I declare that any individual for whom I am requesting continuation 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 understand that I am and at all times will be responsible for timely payment of the full cost of this continuation coverage. I understand that all payments are due by the first of each month. Rates for continuation coverage are available online at **hr.osu.edu/oe**. Checks are payable to "Luminare Health Benefits, Inc." and must be mailed directly to: Luminare Health Benefits COBRA, PO BOX 2905, Clinton IA 52733. 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 Luminare receives timely notification of such change as provided under the applicable plan. I further understand and agree that I must notify Luminare whenever I become (1) covered under any other group health plan; or (2) eligible for Medicare benefits. I understand that coverage may be rescinded (i.e., retroactively terminate) 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 certify that all information provided on this form is true and correct to the best of my knowledge.

Signature | Date

SECTION 4-B: ENROLLEE INFORMATION

Please list self (employee) and/or eligible enrollees (dependents) who are enrolling in COBRA coverage.
Note: The employee is not required to enroll in COBRA benefits if electing coverage only for dependents.

Name	**Relationship to Employee** (see list on other side)	Birth Date	Gender		Address different from employee?[2]		Social Security Number (required)	Choose coverage for each eligible dependent					
								Medical		**Dental**		**Vision**	
		MM/DD/YYYY	**M**	**F**	**YES**	**NO**		**YES**	**NO**	**YES**	**NO**	**YES**	**NO**

[2] If dependent's address differs from employee's address, provide dependent's address in **SECTION 4-C**.

SECTION 4-C: DEPENDENT ADDRESS INFORMATION (IF DIFFERENT FROM EMPLOYEE'S ADDRESS)

If you indicated in SECTION 4-A or 4-B 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

Dependent's Name

Street Address

City State Zip

If you have questions, contact Luminare at 855-580-4838 (8AM EST to 5PM EST).

Return completed form to:
Luminare Health Benefits, Inc.
PO Box 2905
Clinton, IA 52733

Fax: 1-704-527-2162

Email: cobrateamhb@luminarehealth.com

2025 COBRA rates are available online at: **hr.osu.edu/benefits/cobra**.