

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 reside in 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 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. For more information go to: hr.osu.edu/benefits/travel-assistance

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 FORM

Effective date of Out-of-Area Plan Coverage: Beginning Date: _____ Ending Date¹: _____

- 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 outside the network area.

Name of Legal Guardian: First _____ M.I. _____ Last _____ Relationship to Employee _____

- 5. Dependent attending school outside the network area

Name of School _____ Location of School _____

- 6. Other, please specify: _____

Mailing Address: Street _____ City _____ State _____ Zip _____

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

SECTION 3: ENROLLEE INFORMATION

Enrollee Name	Birth Date	Gender	Reason #	Relationship

SECTION 4: 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 Plan 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 Plan 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 _____

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.**