THE OHIO STATE UNIVERSITY

Health Election Medical, Dental, Vision
Affiliated Groups—COTC

SECTION I: PERSONAL INFORMATION

Employee's Full Name First M.I. Last Social Security Number

Address: Street City/State Zip Daytime Phone Number

AFFILIATED GROUP: COTC

SECTION 2: REASON FOR COMPLETING FORM

Date of event: _____/_____/_____ (return form within 30 days of event date or by annual open enrollment deadline)

Qualifying status change (please specify)[1]

- ☐ Hired
- ☐ Newly Eligible
- ☐ Open Enrollment
- ☐ Marriage
- ☐ Other[2] (describe): _____
- ☐ Divorce/Dissolution[2]
- ☐ Birth/Adoption/Legal Guardianship[2]
- ☐ Loss of Other Coverage[2]
- ☐ Change in Dependent Eligibility[2]
- ☐ Termination of Sponsored Dependent Coverage[2]
- ☐ Gained Eligibility for Other Coverage[2]

[1] Refer to Specific Plan Details document(s) for additional details. [2] Documentation may be required.

SECTION 3: HEALTH PLAN COVERAGE SELECTION

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

☐ Prime Care Advantage ☐ Prime Care Choice ☐ Out-of-Area[3,4]

☐ **I waive medical coverage**

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

[3] Special application required for individual access to out-of-area coverage. [4] Premium at Prime Care Advantage rate; eligibility based on qualifying zip code.

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: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Please list self and all family members to whom new coverage or coverage changes will apply. (Use chart on reverse if additional space is needed.) Please use the numbers and letters on reverse to indicate **Relationship to Employee.** Review dependent eligibility guidelines online at **hr.osu.edu/benefits/dependent-eligibility-guidelines**.

Name	Relationship to Employee (use codes on reverse)	Birth Date		Gender		Address different from employee?[5]		Social Security Number (required)	Choose coverage for each eligible dependent					
									Medical		Dental		Vision	
		M/D/Y	AGE	M	F	YES	NO		YES	NO	YES	NO	YES	NO
Employee (named in SECTION I)	0			☐	☐				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐

[5] If dependent's address differs from employee's address, provide dependent's address in **SECTION 6**.

SECTION 5: AUTHORIZATION

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, 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 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 my employer 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 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 Date

THE OHIO STATE UNIVERSITY

Employee Name _______________________________ Employee ID# __________

SECTION 4-B: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

Please list additional family members to whom new coverage or coverage changes will apply.

Name	**Relationship to Employee** (use codes on reverse)	Birth Date		Gender		Address different from employee?[5]		Social Security Number (required)	Choose coverage for each eligible dependent					
									Medical		**Dental**		**Vision**	
		M/D/Y	**AGE**	**M**		**YES**	**NO**		**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐		☐	☐	☐	☐	☐	☐

[5]If dependent's address differs from employee's address, provide dependent's address in **SECTION 6**.

Please use the following numbers and letters to indicate **Relationship to Employee.** Review dependent eligibility guidelines online at **hr.osu.edu/benefits/dependent-eligibility-guidelines**.

0 Employee
1 Spouse
2 Dependent Child (under age 26, unless fully disabled). Please specify:
- **2A** Dependent Child of Employee
- **2B** Dependent Child of Employee's Spouse

After you have enrolled your eligible dependents, a dependent verification packet will be mailed to your home address. All health plan members must provide proof of each covered dependent's eligibility. Failure to provide sufficient proof will result in coverage termination for the dependent(s) not verified.

SECTION 6: 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 ____________

If you have questions, contact your human resources representative. Return completed form to your human resources contact.