2016-17 Domestic Student Interim Insurance Request

FORM USE: Request to enroll in the 2016-17 Comprehensive Student Health Benefits Plan up to four weeks prior to a term’s standard coverage period start date. Standard coverage periods begin 8/16/16 for Autumn 2016 and 01/01/17 for Spring 2017. NOTICE: Interim coverage is granted in weekly increments.

FORM INSTRUCTIONS: Within three (3) business days of your arrival to campus or the termination of current health insurance, submit your completed form and supporting documentation to Student Health Insurance: • shi_info@osu.edu • FAX 614-292-1170 • 1100 Lincoln Tower, 1800 Cannon Dr, Columbus OH 43210. If you have questions, call Student Health Insurance at 614-688-7979.

SECTION A: STUDENT INFORMATION

Last Name: ___________________________________________ Student ID # ___________________________
First Name: ___________________________________________ Date of Birth: ___________________________

SECTION B: EARLY ARRIVAL/LOSS OF COVERAGE INFORMATION

Check one:
___ I’m arriving early for Autumn 2016 (prior to 8/16/16) as required by an academic program or co-curricular activity
___ I’m arriving early for Spring 2017 (prior to 1/1/17) as required by an academic program or co-curricular activity
___ I’m a new graduate/graduate professional student enrolling in my first academic term at Ohio State
___ My health insurance terminates between 7/19/16 and 8/15/16
___ My health insurance terminates between 12/4/16 and 12/31/16

Enter the date of your early arrival/loss of coverage: ________________________________

SECTION C. COVERAGE LEVEL SELECTION (check one)

Note: The coverage you select below must match the coverage you select for the standard coverage period.

___ Student Only
___ Student + Child
___ Student + Spouse
___ Student + 2 or more children
___ Student + Spouse + Child
___ Student + Spouse + 2 or more children

SECTION D: VERIFICATION (check each line to indicate your agreement)

___ I will be enrolled in eligible Ohio State courses during the term for which I am arriving early or that follows my loss of coverage.
___ I understand that the interim coverage level selected above must match the level I select for the standard coverage period.
___ I understand that the interim insurance fee will be added to my university Statement of Account in addition to the standard semester fee, that this fee is not eligible for Graduate or Fellow subsidy, and that fee payment is my sole responsibility.

SIGNATURE: ___________________________________________ DATE: _______________________

Note: Student Health Insurance will send a written decision regarding your request to your Ohio State email address.

FOR OFFICE USE ONLY

Rec'd ___/___/___ Denied □ Approved □ N/A □ By ______________________ Date ___/___/___

Notes: __________________________

SIS Updated: ___/___/___ Student Notified: ___/___/___ Email □ Letter □ Both □ Amt: ________ Eff. Date ________