2016-17 International 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, 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.

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**SECTION A: STUDENT INFORMATION**

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

**SECTION B: EARLY ARRIVAL INFORMATION**

Check one:
___ I’m a new student early arriving for Autumn 2016 (arrival prior to 8/16/16)
___ I’m a new student early arriving for Spring 2017 (arrival prior to 1/1/17)

Enter your date of departure for United States: ____________________________ (Note: You must attach a travel itinerary to verify)
Enter your date of arrival to Columbus, Ohio: ____________________________

**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 box to indicate your agreement)**

___ I have attached a copy of my flight itinerary verifying my departure date.
___ I will be enrolled in eligible Ohio State courses during the term for which I am arriving early.
___ I selected an interim coverage level in Section C that matches the level I selected 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.*