2016-17 Petition to Enroll

FORM USE: Request to enroll in the 2016-17 Comprehensive Student Health Benefits Plan, and document the academic circumstances that cause the credit hour eligibility to not be met.

FORM INSTRUCTIONS: Submit your completed form and required supporting documentation to Student Health Insurance: ● shi_info@osu.edu ● FAX 614-292-1170 ● 1100 Lincoln Tower, 1800 Cannon Dr, Columbus OH 43210. You should submit your petition before the 2nd Friday of the academic term. If you have questions, call Student Health Insurance at 614-688-7979.

SECTION A: STUDENT INFORMATION

Last Name: ____________________ OSU ID # ____________________
First Name: ____________________ OSU Email ____________________
Date of Birth: ____________________ Phone: ____________________
Mailing Address: ____________________________________________

College Department (example: ALP, BUS, ENG): ____________________

SECTION B: COVERAGE TERM REQUEST (check one)

___ Autumn 2016    ___ Spring/Summer 2017    ___ Summer only 2017

SECTION C: COVERAGE LEVEL REQUEST (check one)

___ Student Only

___ Student + Spouse/DP + 2 or more children

___ Student + Spouse/Domestic Partner

___ Student + Child

___ Student + Spouse/Domestic Partner + Child

___ Student + 2 or more children

SECTION D: PRIMARY REASON FOR REQUEST (check one)

___ I’m taking all Distance Learning courses

___ I’m enrolled in the RN to BS Program

___ I’m taking pre-requisite courses toward a degree

➢ Required: Attach an approved pre-requisite curriculum plan or approved graduate application

___ I’m in the Career and Technical Education Teacher Licensure Program

➢ Required: Attach an approved Teacher Licensure Program Curriculum Plan

___ I’m taking a medical or academic leave*

➢ Required: Attach documentation from your College that includes beginning and return dates of your leave.

___ Other

Please specify the circumstance: __________________________________________________________

* Eligibility for leave extended coverage is limited to two (2) terms per academic career. Students who request coverage due to an academic or medical leave must have been enrolled in the Comprehensive Student Health Benefits Plan for the term prior to the leave and have paid the fee in full or the petition will not be considered.
SECTION E: DEPENDENT INFORMATION (required only if your petition request includes dependent coverage)

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<th>Dependent Name (Last, First)</th>
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<th>Gender</th>
<th>Date of Birth</th>
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SECTION F: NOTICES

1. Student Health Insurance will send a written decision regarding your Petition to your Ohio State email address.

2. Student Health Insurance may consult with the Office of Extended Education, the Graduate School, or any applicable College office to verify the information provided. The form and documentation will be used solely for the purpose of this petition.

3. Petitions are valid for one plan year only.

4. If you are granted a petition, the Comprehensive Plan fee will post to your Statement of Account.

5. If you are granted a petition, you are required to maintain Comprehensive Plan enrollment for each term granted unless you no longer meet minimum eligibility.

6. To be eligible for enrollment in the Comprehensive Plan beyond any terms granted in response to this Petition, you must meet minimum credit hour eligibility: 6 for undergraduate, 4 for graduate, and 3 for post-candidacy doctoral.

SECTION G: VERIFICATION

Student’s Signature: _____________________________________________ Date ______________

FOR OFFICE USE ONLY

Rec’d / Date: ____________ Denied □ Approved □ N/A □ By _________________ Date / / ____________

Notes __________________________

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