2023–24 SHI Petition to Enroll

FORM USE: Request to enroll in the 2023–24 Student Health Benefits Plan and document the academic circumstances that cause eligibility to not be met. This form should NOT be used to request enrollment for a Leave of Absence (LOA). Contact our office for assistance with LOA enrollment.

FORM INSTRUCTIONS: Submit your completed form to Student Health Insurance:

shi_info@osu.edu

FAX 614-292-1170

830 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: _____ **Date of Birth (mm/dd/yyyy):** _____

First Name: _____ **OSU ID #:** _____

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

Section B: Coverage Term Request

Check one:

- ☐ Autumn 2023 (AU23 includes enrollment in SP/SU24, if eligible)
- ☐ Spring/Summer 2024
- ☐ Summer only 2024

Section C: Coverage Level Request

Check one:

- ☐ Student Only
- ☐ Student + Spouse/Domestic Partner
- ☐ Student + Spouse/Domestic Partner + Child
- ☐ Student + Spouse/Dom Partner + 2 or more children
- ☐ Student + Child
- ☐ Student + 2 or more children

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Section D: Primary Reason For Request

- ☐ I'm a Domestic Student enrolled in all Distance Learning courses.
- ☐ I'm an International Student enrolled in all Distance Learning courses and I am NOT residing in my home country.
- ☐ I became eligible for Student Health Benefits Plan after the 2nd Friday of the academic term.
- ☐ I'm taking graduate level prerequisite courses toward admission in a graduate program.
  - **REQUIRED:** You must have a current academic year application on file with the Graduate School Administration office
- ☐ **Other, please describe:** _____

Section E: Dependent Information

Required only if your petition request includes dependent coverage

Dependent Name (Last, First)	Relationship	Gender	Date of Birth (Month/Day/Year)

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Section F: Acknowledgements

1. Student Health Insurance will send a written decision regarding this Petition to my university 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 I am granted a petition, I understand I am required to maintain the Student Health Benefits Plan enrollment for each term granted unless I no longer meet minimum eligibility.
5. Rates are available at **shi.osu.edu** and I have reviewed this important information prior to submitting this form.
6. The rate per insured member is **$1796** per semester.
7. When applicable, the pro-rated amount has been provided to me by SHI and I have reviewed this important information.
8. If I am granted a petition, I understand the Student Health Benefits Plan fee will be added to my Statement of Account.
9. Once the fee has been added to my Statement of Account, it cannot be removed, and I will be responsible for payment.
10. Benefits cannot be used until the fee is paid in full.

I acknowledge that I have reviewed and understand all statements in Section F above and that I am responsible to pay the fee of **$1796** per insured member. **Initial Here:** _____

Section G: Signature

Signature: _____ **Date:** ___ / ___ / ___