2023–24 Qualifying Event Form

FORM USE: Request to add, terminate or update coverage in the 2023–24 Student Health Benefits Plan outside of the standard Select / Waive process due to a Qualifying Event.

FORM INSTRUCTIONS: Within 31 days of the Qualifying Event, submit your completed form and required documentation 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 #:** _____

Residency: ☐ Residency ☐ International

Mark a response for BOTH items 1 and 2 below:

1. What is your current SHI level?

- ☐ Waived - No SHI Benefits Plan coverage
- ☐ Student only
- ☐ Student + Spouse / Domestic Partner
- ☐ Student + Spouse / Domestic Partner + Child
- ☐ Student + Spouse / DP + 2 or more children
- ☐ Student + Child
- ☐ Student + 2 or more children

2. What level are you requesting?

- ☐ No SHI Benefits Plan coverage
- ☐ Student only
- ☐ Student + Spouse / Domestic Partner
- ☐ Student + Spouse / Domestic Partner + Child
- ☐ Student + Spouse / DP + 2 or more children
- ☐ Student + Child
- ☐ Student + 2 or more children

Section B: Your Event

1. What date did the change occur? (Month / Day / Year): _____

For example: When did your new job start? When did you get married? When did your other coverage involuntarily end?

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2. In the left column, mark the Qualifying Event that applies to you. The right column indicates the required documentation.

Table I. Add coverage for me and/or my dependents	
Check One	**Documentation Required**
☐ I reached the **AGE LIMIT** of my other coverage.	• Letter from insurance company indicating age limit reached and coverage loss date
☐ Because of a **JOB LOSS**, I lost my other coverage involuntarily.	• Letter/documentation from employer or insurance company with termination date
☐ I have a **NEWBORN** or **NEWLY ADOPTED CHILD.***	• Hospital document with date of birth; Adoption document with date of placement
☐ I have a **NEW SPOUSE.***	• Marriage Certificate
☐ I have a **NEW DOMESTIC PARTNER.***	• Certificate from City of Columbus Domestic Partner Registry
☐ I have a dependent(s) who newly arrived in U.S. from their foreign homeland.*	• Most Recent I-94 AND Travel History
☐ I was assigned new responsibility to insure my dependent.*	• Legal document with date and specification of requirement
☐ Because of a DIVORCE, I lost my other coverage involuntarily.	1. Divorce Certificate 2. Letter/documentation from employer or insurance company with termination date
☐ I experienced other involuntary coverage loss and am attaching documentation to verify the following:	

**You must have existing SHI Coverage to request to add dependents. If you currently have a waiver, a new dependent is not a Qualifying Event.*

Table II. Terminate coverage for me and/or my dependents	
Check One	**Documentation Required**
☐ I/my family has a **NEW JOB/POSITION** with new eligibility for a new employer insurance plan.*	1. Letter from employer specifying new job/position start date and new eligibility for coverage. 2. Evidence of your new coverage (for example, Member ID Card or insurance company document showing Member ID)
☐ I have new eligibility for a new insurance plan through a **NEW SPOUSE.***	1. Marriage Certificate. 2. Evidence of your new coverage (for example, Member ID Card or insurance company document showing Member ID)
☐ I have new eligibility for a new insurance plan through a **NEW DOMESTIC PARTNER.***	• Evidence of your new coverage (for example, Member ID Card or insurance company document showing Member ID).
☐ Because of a **DIVORCE**, I need to remove my dependent(s).*	• Divorce Certificate
☐ Because of a **TERMINATION of DOMESTIC PARTNERSHIP**, I need to remove my dependent(s).*	• City of Columbus Domestic Partnership Registry Notice of Termination of Domestic Partner Form
☐ My dependent(s) returned to their foreign homeland.*	• Most Recent I-94 AND Travel History
☐ I received notification of retroactively awarded Medicaid eligibility. NOTE: You must have applied for Medicaid prior to your first Select/Waive deadline of the academic year.	1. Medicaid Notice of Action document. 2. Member portal eligibility screenshot.

*Termination will begin at the start of the coverage period subsequent to the period containing the Qualifying Event. No fee refunds will be issued for the coverage period containing your Qualifying Event.

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Section C: Dependent Information

(Required only if you are enrolling an eligible dependent: ex: spouse, child, etc.)

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

Section D: Acknowledgement

1. Forms submitted more than 31 days after your Qualifying Event date will not be processed. If you miss the 31-day deadline, your next opportunity to change your status will be the next policy year, which begins in autumn.
2. You must attach documentation that verifies the Qualifying Event. The list of allowable Qualifying Events is available at shi.osu.edu and on Page 2 of this form.
3. Student Health Insurance will send a written decision regarding this Qualifying Event to my university email address.
4. Approved requests to add SHI coverage are processed for the coverage period containing the Qualifying Event. Coverage will begin the date of the Qualifying Event and a prorated fee will post to your university Statement of Account.
5. Rates are available at **shi.osu.edu** and I have reviewed this important information prior to submitting this form.
6. When applicable, the pro-rated amount has been provided to me by SHI and I have reviewed this important information.
7. Once the fee has been added to my Statement of Account, it cannot be removed, and I will be responsible for payment.
8. Benefits cannot be used until the fee is paid in full.
9. Coverage will remain in effect for all subsequent coverage periods within the policy year. The fee for subsequent coverage periods will post to your university Statement of Account at the beginning of each coverage period.
10. Approved requests to terminate SHI Benefits Plan coverage go into effect for the coverage period *subsequent to the period containing the Qualifying Event*. **No fee refunds will be issued for the current coverage period**. Requests to terminate coverage due to a Qualifying Event that occurs during spring/summer will not be effective for spring/summer; the next opportunity to waive will be the next policy year beginning in autumn.

I acknowledge that I have reviewed and understand all Acknowledgements in Section D of this form.

Initial Here: _____

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Section E: Verification

My signature below verifies the following: I am requesting a change to my current Student Health Benefits Plan coverage level. I am providing documentation that verifies my Qualifying Event.

Signature: _____ **Date:** / /