2022-23 SHI Petition to Enroll

THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE
STUDENT HEALTH INSURANCE

FORM USE: Request to enroll in the 2022-23 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: _____ **OSU ID #** _____

First Name: _____ **Date of Birth:** _____

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

SECTION B: COVERAGE TERM REQUEST (check one) *

___ Autumn 2022 (AU22 includes enrollment in SP/SU23 if eligible)

___ Spring/Summer 2023

___ Summer only 2023

*Your selection of the Student Health Benefits Plan remains in effect for the remainder of the policy year, and you cannot modify your selection from term to term.

SECTION C: COVERAGE LEVEL REQUEST (check one)

___ 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 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'm an undergraduate in a non-degree program taking pre-requisite courses toward admission in a degree program

- Required: Attach an approved academic projection plan

___ I'm taking graduate level pre-requisite courses toward admission in a graduate program

- Required: You must have an approved graduate application on file with the Graduate School Administration office

___ Other, please describe: _____

_____

Last Revision 11/04/2022

SECTION E: DEPENDENT INFORMATION (required only if your petition request includes dependent coverage)

Dependent Name (Last, First)	Relationship	Gender	Date of Birth

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 $1765.00 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 $1765 per insured member. Initial here: _____

SECTION G: SIGNATURE

Signature of Student _____ **Date** _____

FOR OFFICE USE ONLY

Rec'd_____/_____/_____ Denied ☐ Approved ☐ N/A ☐ By_____ Date_____/_____/_____

Notes_____

SIS Updated: _____/_____/_____ Student Notified: _____/_____/_____ Email ☐ Letter ☐ Both ☐ Amt: _____ Eff. Date_____