2020-21 Petition to Enroll

FORM USE: Request to enroll in the 2020-21 Student Health Insurance 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 ● 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: ____________________ OSU Email ____________________

Date of Birth: ____________________ Phone: ____________________

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

SECTION B: COVERAGE TERM REQUEST (check one) *

___ Autumn 2020 (AU20 includes enrollment in SP/SU21 if eligible)

___ Spring/Summer 2021

___ Summer only 2021

* Your Selection of the SHI Benefits Plan remains in effect for the remainder of the policy year and you cannot modify your selection from term to term. Rates and fee payment options are available at shi.osu.edu. Please review this important information prior to submitting this form.

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 (check one)

___ 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 enrolled in the RN to BS Program

___ I'm enrolled in the College of Nursing Graduate Program with all Distance Learning courses

- *Required: Attach documentation from the College of Nursing*

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

- *Required: Attach an approved academic projection 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*

___ Other, *please describe:* ____

____

FORM CONTINUES ON NEXT PAGE

Last Update: 08/07/2020

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

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

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 Student Health Insurance Benefits Plan fee will post to your Statement of Account.
5. If you are granted a petition, you are required to maintain the Student Health Benefits Plan enrollment for each term granted unless you no longer meet minimum eligibility.
6. To be eligible for enrollment in the Student Health Insurance Benefits 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______/______/______ Denied ☐ Approved ☐ N/A ☐ By____________________ Date______/______/______

Notes____

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