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 (your annual selection of Autumn 2020 includes enrollment in Spring/Summer 2021 if eligible)
___ Spring/Summer 2021
___ Summer only 2021

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 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  Page 1 of 2
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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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_______