

# 2022-23 Coverage Status Change Form



**THE OHIO STATE  
UNIVERSITY**

OFFICE OF STUDENT LIFE  
STUDENT HEALTH INSURANCE

**FORM USE:** Request to add, terminate or update coverage in the 2022-23 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:** \_\_\_\_\_ **OSU ID #:** \_\_\_\_\_  
**First Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Residency:**    \_\_\_ Domestic        \_\_\_ 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?

- Waive - 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 was the event? (Month / Day / Year):** \_\_\_\_\_

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

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

<b>TABLE I. Add coverage for me and/or my dependents</b>	
<i>CHECK ONE</i>	<i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> I reached the AGE LIMIT of my other coverage.	<ul style="list-style-type: none"> <li>Letter from insurance company indicating age limit reached and coverage loss date</li> </ul>
<input type="checkbox"/> Because of a JOB LOSS, I lost my other coverage involuntarily.	<ul style="list-style-type: none"> <li>Letter/documentation from employer or insurance company with termination date</li> </ul>
<input type="checkbox"/> Because of a DIVORCE, I lost my other coverage involuntarily.	<ol style="list-style-type: none"> <li>Divorce Certificate</li> <li>Letter/documentation from employer or insurance company with termination date</li> </ol>
<input type="checkbox"/> I attained eligibility after the 2nd Friday of the academic term.	--- N/A – Staff will verify in Buckeye Link ---
<input type="checkbox"/> I have a NEWBORN OR NEWLY ADOPTED CHILD.*	<ul style="list-style-type: none"> <li>Hospital document with date of birth; Adoption document with date of placement</li> </ul>
<input type="checkbox"/> I have a NEW SPOUSE.*	<ul style="list-style-type: none"> <li>Marriage Certificate</li> </ul>
<input type="checkbox"/> I have a dependent(s) who newly arrived in U.S. from their foreign homeland.*	<ul style="list-style-type: none"> <li>Stamped passport or visa</li> </ul>
<input type="checkbox"/> I was assigned new responsibility to insure my dependent.	<ul style="list-style-type: none"> <li>Legal document with date and specification of requirement</li> </ul>
<input type="checkbox"/> 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.

<b>TABLE II. Terminate coverage for me and/or my dependents</b>	
<i>CHECK ONE</i>	<i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> I/my family has a NEW JOB/POSITION with new eligibility for a new employer insurance plan.	<ol style="list-style-type: none"> <li>Letter from employer specifying new job/position start date and new eligibility for coverage.</li> <li>Evidence of your new coverage (for example, Member ID Card or insurance company letter)</li> </ol>
<input type="checkbox"/> I have new eligibility for a new insurance plan through a NEW SPOUSE.	<ol style="list-style-type: none"> <li>Marriage Certificate.</li> <li>Evidence of your new coverage (for example, Member ID Card or insurance company letter)</li> </ol>
<input type="checkbox"/> I have new eligibility for a new insurance plan through a NEW DOMESTIC PARTNER.	<ul style="list-style-type: none"> <li>Evidence of your new coverage (for example, Member ID Card or insurance company letter).</li> </ul>
<input type="checkbox"/> Because of a DIVORCE, I need to remove my dependent(s).	<ul style="list-style-type: none"> <li>Divorce Certificate</li> </ul>
<input type="checkbox"/> Because of a termination of Domestic Partnership, I need to remove my dependent(s).	<ul style="list-style-type: none"> <li>Termination of Domestic Partner Status form (available at <a href="http://shi.osu.edu/important-forms">shi.osu.edu/important-forms</a>)</li> </ul>
<input type="checkbox"/> My dependent(s) returned to their foreign homeland.	<ul style="list-style-type: none"> <li>Copy of airplane ticket or itinerary</li> </ul>
<input type="checkbox"/> 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.	<ol style="list-style-type: none"> <li>Medicaid Notice of Action document.</li> <li>Member portal eligibility screenshot.</li> </ol>

REMINDER: Newly selecting employer or marketplace insurance during an annual Open Enrollment period is not a Qualifying Event.

**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: ACKNOWLEDGEMENTS**

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](http://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:** \_\_\_\_\_

**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 of Student \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE ONLY

Rec'd \_\_\_\_/\_\_\_\_/\_\_\_\_ Approved  Denied  N/A  By \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Undergrad  Grad  Grad Professional  Subsidy  International  Domestic

Campus: Columbus  Lima  Marion  Mansfield  Newark  ATI

SIS Updated: \_\_\_\_/\_\_\_\_/\_\_\_\_ Student Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email  Fee: \_\_\_\_\_ Eff. Date \_\_\_\_\_

Notes: \_\_\_\_\_