2018-19 Coverage Status Change Form

THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE
STUDENT HEALTH INSURANCE

FORM USE: Request to add, terminate or update SHI Benefits Plan coverage 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 ● 1100 Lincoln Tower, 1800 Cannon Dr, Columbus OH 43210. If you have questions, call Student Health Insurance at 614-688-7979.

SECTION A: NOTICES

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. 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. The Student Health Insurance office will notify UnitedHealthcare StudentResources and Delta Dental of Ohio of your new coverage.
4. **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.**

SECTION B: YOUR INFORMATION

Last Name: _____ **OSU ID #:** _____

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

OSU Email: _____ **Phone Number:** _____

Mailing Address: _____

_____

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 or Domestic Partner
___ Student + Spouse or 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 or Domestic Partner
___ Student + Spouse or Domestic Partner + Child
___ Student + Spouse/DP + 2 or more children
___ Student + Child
___ Student + 2 or more children

SECTION C: 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. Mark your event in the left column for the table 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
___ 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 attained eligibility after the 2nd Friday of the academic term.	--- N/A – Staff will verify in Buckeye Link ---
___ 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.*	• Notarized *Affidavit of Domestic Partnership* form (available at shi.osu.edu/important-forms)
___ I have a dependent(s) who newly arrived in U.S. from their foreign homeland.*	• Stamped passport or visa
___ I was assigned new responsibility to insure my dependent.	• Legal document with date and specification of requirement
___ 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 letter)
___ 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 letter)
___ 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 letter).
___ 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).	• *Termination of Domestic Partner Status* form (available at shi.osu.edu/important-forms)
___ My dependent(s) returned to their foreign homeland.	• Copy of airplane ticket or itinerary
___ 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.

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

SECTION D: DEPENDENT INFORMATION (required only if you are enrolling an eligible dependent)

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

SECTION E: VERIFICATION

My signature below verifies the following: I am requesting a change to my current SHI coverage level. I understand the notices in Section A of this form. I am providing documentation that verifies my Qualifying Event.

Student Signature: _____ **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: _____