

2018-19 International Student Interim Insurance Request



THE OHIO STATE
UNIVERSITY

OFFICE OF STUDENT LIFE
STUDENT HEALTH INSURANCE

FORM USE: Request to enroll in the 2018-19 Student Health Insurance Benefits Plan up to four weeks prior to a term's standard coverage period start date. Standard coverage periods begin 8/14/18 for Autumn 2018 and 01/01/19 for Spring 2019. **NOTICE:** Interim coverage is granted in weekly increments.

FORM INSTRUCTIONS: Within three (3) business days of your arrival to campus, submit your completed form and 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: _____ Student ID # _____

First Name: _____ Date of Birth: _____

SECTION B: EARLY ARRIVAL INFORMATION

Check one:

___ I'm a new student early arriving for Autumn 2018 (arrival prior to 8/14/18)

___ I'm a new student early arriving for Spring 2019 (arrival prior to 1/1/19)

Enter your date of departure for United States: _____ (Note: You must attach a travel itinerary to verify)

Enter your date of arrival to Columbus, Ohio: _____

SECTION C. COVERAGE LEVEL SELECTION (check one)

Note: The coverage you select below must match the coverage you select for the standard coverage period.

___ Student Only

___ Student + Child

___ Student + Spouse

___ Student + 2 or more children

___ Student + Spouse + Child

___ Student + Spouse + 2 or more children

SECTION D: VERIFICATION (check each box to indicate your agreement)

___ I have attached a copy of my flight itinerary verifying my departure date.

___ I will be enrolled in eligible Ohio State courses during the term for which I am arriving early.

___ I selected an interim coverage level in Section C that matches the level I selected for the standard coverage period.

___ I understand that the interim insurance fee will be added to my university Statement of Account in addition to the standard semester fee, that this fee is not eligible for Graduate or Fellow subsidy, and that fee payment is my sole responsibility.

SIGNATURE: _____ **DATE:** _____

Note: Student Health Insurance will send a written decision regarding your request to your Ohio State email address.

FOR OFFICE USE ONLY

Rec'd _____/_____/_____ Denied Approved N/A By _____ Date _____/_____/_____

Notes

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