2019-20 International Student Interim Insurance Request

FORM USE: Request to enroll in the 2019-20 Student Health Insurance Benefits Plan up to four weeks prior to a term’s standard coverage period start date. Standard coverage periods begin 8/13/19 for Autumn 2019 and 01/01/20 for Spring 2020. 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 2019 (arrival prior to 8/13/19)
___ I’m a new student early arriving for Spring 2020 (arrival prior to 1/1/20)

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 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 ______