2018-19 Petition to Enroll

FORM USE: Request to enroll in the 2018-19 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 • 1100 Lincoln Tower, 1800 Cannon Dr, Columbus OH 43210. You should submit your petition before the 2nd Friday of the academic term. 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: _____________________________
Mailing Address: ____________________________________________________________
College Department (example: ALP, BUS, ENG): ________________________________

SECTION B: COVERAGE TERM REQUEST (check one)

___ Autumn 2018       ___ Spring/Summer 2019       ___ Summer only 2019

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 enrolled in all Distance Learning courses
___ 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

___ I’m taking a medical or academic leave*
  ➢ Required: Attach documentation from your College that includes beginning and return dates of your leave.

___ Other, please describe: ______________________________________________________

* Eligibility for leave extended coverage is limited to two (2) terms per academic career. Students who request coverage due to an academic or medical leave must have been enrolled in the Student Health Insurance Benefits Plan for the term prior to the leave and have paid the fee in full or the petition will not be considered.
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______