Ohio University Benefits Enrollment

Forms are due within 31 days of a Qualifying Event along with supporting documentation of that event.

SECTION 1: EMPLOYEE’S PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>OU Employee ID</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address: __________________________________________

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Ohio ID (first part of email address)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 2: REASON FOR APPLICATION

- New Hire
- Divorce
- Child Reached 28
- Dependent Gains Other Coverage
- Other

- Open Enrollment
- Death
- Child Reached 26
- Dependent Loses Other Coverage
- Other

- Marriage
- Birth / Adoption / Legal Custody
- Change of Spouse / Partner’s Employment

DATE OF QUALIFYING EVENT __________

SECTION 3: MEDICAL PLAN OPTIONS

- PPO Employee Only
- PPO Employee and One Dependent (Spouse / Domestic Partner / Child)
- PPO Employee and Family
- OPT OUT of Ohio University’s medical coverage.

Attach Completed Waiver of Group Health Insurance form

- I am covered under an Ohio University Employee:

  NAME: Last, First M.I.  

  Employee ID Number

SECTION 4: DENTAL PLAN OPTIONS

Choose only ONE of the following options

- Dental Employee Only (free for full-time employees)
- Dental Employee and One Dependent
- Dental Employee and Family
- OPT OUT of Dental Coverage

OR

- Dental and Orthodontia
- Dental and Orthodontia Employee Only
- Dental and Orthodontia Employee and One Dependent
- Dental and Orthodontia Employee and Family
- OPT OUT of Dental and Orthodontia Coverage

SECTION 5: FLEXIBLE SPENDING ACCOUNT

Enter TOTAL amount to be deducted over the remainder of the plan year (July 1st – June 30th)

- Health Account

  $  
  (Maximum $2,500)

- Dependent Day Care

  You can use your Dependent Day Care Spending Account to pay for nursery school or day care for your child, and in-home care for a dependent adult.

  $  
  (Maximum $2,500 if you are married and file your taxes separately; $5,000 if you are single or you are married and file your taxes jointly)

SECTION 6: LIFE INSURANCE

Attach completed Life Beneficiary Form

- Supplemental Life

  $  
  (Coverage in increments of $10,000 up to $500,000)

- Dependent Life

  CHOOSE ONE OPTION

  - Option A ($10,000 Spouse, $5,000 each child)
  - Option B ($5,000 Spouse, $2,000 each child)
  - Option C ($20,000 Spouse, $10,000 each child)

PART-TIME CLASSIFIED EMPLOYEES must purchase Basic Life Insurance to enroll in Supplemental Coverage  

Check here to enroll.
SECTION 7: DEPENDENT INFORMATION - This section **MUST** be completed for all dependents you wish to cover. Supporting documentation (i.e. Spouse - Marriage license, Child – Birth Certificate) **MUST** be submitted for each dependent covered. See [Verification of Dependents](http://www.ohio.edu/hr/benefits/healthcare/verification.cfm) for a complete listing of acceptable documents.

### SPOUSE / DOMESTIC PARTNER

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Relationship</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
</tbody>
</table>

Spouse/partner employed outside Ohio University? □ Y □ N  If yes, continue with next question

Does that employer offer health insurance? □ Y □ N  If yes, continue with next question

Are they enrolled in that employer’s coverage? □ Y □ N  If yes, please attach proof of coverage

### CHILD

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Relationship</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
</tbody>
</table>

*Answer questions below if your child is age 26 OR 27*

Ohio Resident? □ Y □ N

Married? □ Y □ N

Permanently Disabled? □ Y □ N

FULL-TIME student? □ Y □ N

Covered by Medicaid or Medicare? □ Y □ N

Employed & Eligible for health care coverage? □ Y □ N

ADDRESS:

- Street
- City
- State
- Zip

### CHILD

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Relationship</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
</tbody>
</table>

*Answer questions below if your child is age 26 OR 27*

Ohio Resident? □ Y □ N

Married? □ Y □ N

Permanently Disabled? □ Y □ N

FULL-TIME student? □ Y □ N

Covered by Medicaid or Medicare? □ Y □ N

Employed & Eligible for health care coverage? □ Y □ N

ADDRESS:

- Street
- City
- State
- Zip

### CHILD

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Relationship</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
</tbody>
</table>

*Answer questions below if your child is age 26 OR 27*

Ohio Resident? □ Y □ N

Married? □ Y □ N

Permanently Disabled? □ Y □ N

FULL-TIME student? □ Y □ N

Covered by Medicaid or Medicare? □ Y □ N

Employed & Eligible for health care coverage? □ Y □ N

ADDRESS:

- Street
- City
- State
- Zip

### CHILD

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Relationship</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
</tbody>
</table>

*Answer questions below if your child is age 26 OR 27*

Ohio Resident? □ Y □ N

Married? □ Y □ N

Permanently Disabled? □ Y □ N

FULL-TIME student? □ Y □ N

Covered by Medicaid or Medicare? □ Y □ N

Employed & Eligible for health care coverage? □ Y □ N

ADDRESS:

- Street
- City
- State
- Zip

If your child is 26 or 27 please attach a completed [Extended Dependent Benefits Enrollment Form](http://www.ohio.edu/hr/benefits/healthcare/eligibility.cfm). An additional premium will apply for 26 and 27 year olds see [http://www.ohio.edu/hr/benefits/healthcare/eligibility.cfm](http://www.ohio.edu/hr/benefits/healthcare/eligibility.cfm) for more details.
SECTION 8: AUTHORIZATION

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy(ies) issued to or by Ohio University. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective my insurance will not begin until the day I meet the policy definition of actively at work. For those insurance coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire required.

I certify all information is true and correct to the best of my knowledge. I understand that my elections may not be changed or voluntarily canceled at any time during the plan year unless a qualifying family status change or other qualifying event, as defined by federal regulations, occurs. Otherwise, I may only cancel or make changes during the annual open enrollment.

Please Note: Rates for part-time classified employees are based on hours worked each pay period.

I understand I must submit this enrollment form and required dependent verification documentation within 31 days of my hire date or Qualifying Family Status Change in order for your coverage to become effective; otherwise I must wait until the next open enrollment period to enroll.

EMPLOYEE SIGNATURE _____________________________ DATE ______________

Please complete the Life Beneficiary Form.

Incomplete information will result in a delay in processing your enrollment.