

Short-Term Disability (STD) Election

If you are currently in an eligible enrollment period for short-term disability (STD) coverage, you have 31 days from the eligible event date to submit your election form. Enrollment at any other time requires medical Evidence of Insurability (EOI). Existing coverage may be cancelled only during Open Enrollment or within 31 days of an eligibility status change. Submit appropriate documentation with this form to the Office of Human Resources.

SECTION I: PERSONAL INFORMATION (print or type)

Faculty/Staff Member's Full Name:

First	M.I.	Last	OSU Employee ID Number	
Home Address: Street		City	State	Zip Code
E-mail Address		Daytime Phone Number		

SECTION II: ELECTION OF COVERAGE AND SALARY DEDUCTION

- I elect to **enroll** in STD coverage and authorize the salary deduction as shown below. Medical Evidence of Insurability (EOI) may be required. There is no annual Open Enrollment period for STD coverage.
- I **decline** enrollment in STD coverage.
- I elect to **cancel** my current enrollment in STD coverage during an eligible annual Open Enrollment period; coverage **change to be effective** on the first day of the plan year following the Open Enrollment period.
- I elect to **cancel** my enrollment in STD coverage as a result of the eligibility status change listed below; coverage **change to be effective** on the first day of the pay period following receipt of the STD Election/Change Form.

Date of employment (FTE) or hire date: _____

Date of status change: _____ (return within 31 days)

- Hired/Newly eligible Divorce¹ Death of a Spouse Birth/Adoption/Legal Guardianship/Legal Custody^{1,2}
- Late Enrollee (completion of **EOI** form is required, online at hr.osu.edu/forms/#std)

¹Documentation may be required. ²Not a qualification for cancellation of coverage.

Premium Rates Effective January 1–December 31, 2012

I am paid Monthly Biweekly

My base annual salary is:	My deduction (after-taxes) per pay period will be:	
	Biweekly	Monthly
<input type="checkbox"/> \$29,999 or less	\$ 4.50	\$ 9.75
<input type="checkbox"/> \$30,000–\$69,999	8.90	19.29
<input type="checkbox"/> \$70,000 or more	18.26	39.57

SECTION III: AUTHORIZATION

I hereby authorize the salary deduction as stated herein. I certify that all information provided on this form is true and correct to the best of my knowledge. I understand that this Agreement will remain in effect until I cancel my enrollment during a subsequent enrollment period or transfer to an ineligible appointment. I understand that any person who, knowingly and with intent to defraud, files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

Signature _____ Date _____

If you have questions, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, hr.osu.edu, (614) 292-1050, 1-800-678-6010.

Keep a copy of this form for your personal records as it may prove to be valuable documentation.

Return completed form to:

The Ohio State University, Office of Human Resources, Benefits Processing/Disability, 1590 N. High St., Suite 300, Columbus, OH 43201-2190; Fax: (614) 292-7813