

Section I: Personal Information

Employee's Full Name: Last First MI

Daytime Phone E-mail Address OSU Employee ID # (required)

- Reason for completing form:
- Unpaid Court Appearance
 - Unpaid Family and Medical Leave (FML) — skip Section II
 - Unpaid Medical Leave (Employed less than one year)
 - Unpaid Medical Leave (Employed one or more years) — skip Section II
 - Unpaid Personal Leave

Expected return to work date _____

Section II: Benefit Elections (May only continue coverage in programs currently enrolled)

Benefit Programs:	CONTINUE	WAIVE
Medical Coverage	<input type="checkbox"/>	<input type="checkbox"/>
Dental Coverage	<input type="checkbox"/>	<input type="checkbox"/>
Vision Coverage	<input type="checkbox"/>	<input type="checkbox"/>
Group Term Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Group Life Insurance (DGLI)	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Disability (LTD)	<input type="checkbox"/>	<input type="checkbox"/>

Section III: Benefit Elections (May only continue coverage in programs currently enrolled)

Benefit Programs:	CONTINUE	WAIVE
Flexible Spending Account—Health Care	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Group Term Life Insurance (VGTLI)	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Disability (STD)	<input type="checkbox"/>	<input type="checkbox"/>

Section IV: Payment Election

Indicate payment method for benefits being continued during leave:

Monthly Direct Payments Lump Sum Payment Prior to Leave

Section V: Certification

I have received, read, and understand the material explaining the terms and conditions of The Ohio State University Health Plans. I declare that any individual for whom I am requesting health coverage meets the definition of an eligible dependent as stated in the specific Health Plan Detail, available online at hr.osu.edu, I understand that any person who, knowingly and with intent to defraud, applies for coverage or files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year (January 1–December 31) unless a qualifying status change occurs, as defined by the plan. The Office of Human Resources Customer Service Center must receive notification of the change within 31 days. I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature of Applicant Date

Payments are due: On the first day of each month during the leave. **Make checks payable to:** The Ohio State University

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

Return completed form to: Office of Human Resources, Benefits Processing/Leaves, Suite 300, 1590 North High Street, Columbus, OH 43201-2190.