Office of HUMAN RESOURCES — THE OHIO STATE UNIVERSITY

OUT-OF-AREA BENEFIT Election Form

Access to out-of-area coverage is available with this special application to individuals enrolled in Prime Care Advantage, Prime Advantage Value, or Prime Advantage Plus who will be outside Ohio for at least 30 consecutive days.

Benefits for medical services received outside of Ohio while on approved out-of-area coverage will be paid in accordance with the Out-of-Area Plan.

Note: When seeking care outside Ohio or the U.S., use GlobalCare referral services.

Section I: Personal Information (Please print or type)

Employee's Full Name

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

Section II: Reason for Completing Form[1]

Effective date of Out-of-Area Benefit: Beginning Date __________ Ending Date __________

- ☐ 1. Faculty on Sabbatical (residence outside of the area for greater than 30 days)
- ☐ 2. Faculty/Staff on Off-Duty Quarter (residence outside of the area)
- ☐ 3. Faculty/Staff on approved Leave of Absence (residence outside of the area for greater than 30 days)
- ☐ 4. Dependent child living with a primary guardian who lives outside the area

  Name of Legal Guardian | Relationship to Employee:

- ☐ 5. Dependent attending college outside the area

  Name of School | Location of School:

- ☐ 6. Other, please specify: __________

  Mailing address

Section III: Enrollee Information (Name of person(s) applying for Out of Area Benefit)

Enrollee Name	Social Security Number	Birthdate	Gender	Reason #	Relationship

Section IV: Certification

I certify that the above named individuals meet the stated eligibility requirements for enrollment in the Out-of-Area Benefit. I realize that once the covered individuals return to visit or for permanent residency in the area, they must utilize network facilities. I understand that my elections may not be changed during the plan year unless a qualifying status change occurs, as defined by federal regulations.

I also understand that if a qualifying status change occurs, I must complete a Health Election Form within 31 days of the event (available online at hr.osu.edu/forms).

I certify that all information provided on this form is true and correct to the best of my knowledge. I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, including claiming persons who are not legal dependents, is guilty of insurance fraud.

Signature of Applicant | Date

If you have additional 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: The Ohio State University, Office of Human Resources, Benefits Processing, 1590 North High Street, Suite 300, Columbus, OH 43201-2190, or Fax to: (614) 292-7813.

[1] An extension must be filed if outside the area after the end date.