

**Before filling out your Prime Care Connect application, please make sure that these four statements are true:**

1. I am not an employee of an affiliated group (Central Ohio Technical College, OSU Physicians) or a Graduate Associate.
2. I am a full-time university employee (75-100% FTE) in a Regular, Term or Seasonal appointment.
3. I am applying for Open Enrollment or because of a qualifying event. See below (#11) regarding eligibility.
4. My adjusted gross household income is not more than the maximum amount listing in the chart for the number of people in my household.

Persons in Household	Maximum Household Income
1	\$32,805
2	\$44,370
3	\$55,935
4	\$67,500
5	\$79,065
6	\$90,630
7	\$102,195
8	\$113,760
For families/households with more than 8 persons, add \$11,565 for each additional person.	

If you need help completing the application, or have any questions, please call OSU Health Plan at **614-292-4700** or **800-678-6269** or email [OSUHealthPlanCS@osumc.edu](mailto:OSUHealthPlanCS@osumc.edu).

You will need these **numbers** and **tax returns** to complete this application. Check the box once you have gathered this information:

- Your **Employee ID Number**
- Your **most recent tax return (1040, 1040A, or 1040EZ)** (see the last page of this application for an example of a tax return)
- Your **spouse's most recent tax return (1040, 1040A, or 1040EZ)** if you filed separately
- Most recent tax returns (1040, 1040A, or 1040EZ) of everyone over 18 years old** living in your home
- Social Security Numbers of all family members** who live with you in your home

**SPECIAL NOTE:** If you are applying as a new hire or qualifying event, newly eligible or have a qualifying event please also enroll in one of the other Ohio State medical coverage options during Open Enrollment period, while waiting to hear if you are approved for Prime Care Connect. That way, you know you will have coverage if you are not approved.

**Note:** You are not eligible for this coverage if you are an employee of an affiliated group (COTC, OSUP), or a graduate associate. To be eligible you must hold a full-time university appointment (75-100% FTE) in a Regular or Term appointment.

If you are approved for Prime Care Connect, you will automatically be enrolled effective from your date of hire or the date for your Qualifying Event. You will receive a letter from the OSU Health Plan advising whether you have been approved.

**What is a Qualifying Event?** Major life events such as birth or adoption of a child, marriage, or open enrollment.

**What is a dependent?** A child or other individual who you claim as a personal exemption tax deduction on your tax return.

**Your application will not be processed if all information is not provided on the form.** If you would like an example to check your work, see the last three pages of this packet.

If you need help completing the application, please call OSU Health Plan at **614-292-4700** or **800- 678-6269** or email **OSUHealthPlanCS@osumc.edu**.

## INSTRUCTIONS

### EMPLOYEE INFORMATION

1. Write your employee information on lines 1–10 of the application.

### INCOME INFORMATION

2. Write your most recent adjusted gross income on line 4 of the application. If your household income has changed significantly since your most recent tax return, you will have to provide more information (see instruction number 6.)

### FAMILY INFORMATION

3. Write the name of your spouse, all household members and any dependents who do not live with you that you would like to enroll in the medical plan. **Be sure to include the birthdate, gender, and the social security number of all the household members to be enrolled in Prime Care Connect.**

4. Include the most recent income amount from the tax return of all household members, and dependent(s) not living in the home that you would like to enroll in the medical plan, over the age of 18.

5. Tell us whether each person is living with you and if you want them enrolled in the Prime Care Connect medical plan, if approved, by circling “yes” or “no.”

6. Include copies of your most recent tax return—1040, 1040A, or 1040EZ—as well as your spouse’s, any other adult person living in your home, and any adult dependent not living in your home that you would like to enroll in the medical plan (see attached for example of a tax return), including copies of the forms, schedules, and any other supporting documentation that make up your total adjusted gross income.

**If you do not have a copy of your most recent tax return, you can request a tax return transcript free of charge by calling the IRS toll free at 800-829-0922 Monday through Friday, 7 a.m. to 10 p.m.** For faster delivery, if you have access to a fax machine, you can fax your transcript instead of mailing it.

When the transcript(s) arrive(s), include a copy along with the completed application and other necessary documents we have asked for. **Do not send ANY original documents, please keep the originals for your records, and ONLY send copies. No documents will be returned to you.**

7. If you, your spouse, adult dependents living outside of the home that you wish to enroll in the medical plan, or other adults living in your home did not file a tax return in latest tax season, provide the most recent W-2 from everyone’s employers. For Ohio State employees, you can request a copy of your most recent W-2 by visiting Employee Self Service, choosing “W-2 Forms” and clicking on “Year End Form” for the year 2022.

If you do not have internet access, you can request a copy of your Ohio State W-2 by calling 800-996-7566 between 8 a.m. and 9 p.m. For non-Ohio State employees, contact your most recent employer.

8. The OSU Health Plan may contact you if you have not given us all the information we need to process your application.

9. Notification of approval or denial of your eligibility for Prime Care Connect will be mailed to the address listed on the application within 10 business days from the date your completed application and needed documentation is received.

10. Approvals will be sent to the Office of Human Resources for appropriate processing of enrollment; however, no income information from your application will be shared with the Office of Human Resources.

11. Your eligibility is valid only for the plan year, and you must reapply annually to keep your eligibility.

12. Make sure your application is complete, then print and sign your name and today’s date on page 5, to verify that the information is valid and accurate.

13. Mail the completed application and requested documents to: The OSU Health Plan, 700 Ackerman Road, Suite 1007, Columbus, OH 43202, email to OSUHealthPlanCS@osumc.edu, or fax the materials to 614-292-2667.

## OSU Prime Care Connect Medical Plan – Application

Submit this completed application along with any of the applicable documents.

**If you filed for a tax return in the last year, you must submit:**

- Copy or transcript of your most recent income tax return (1040, 1040A, or 1040 EZ), and
- Copy or transcript of the most recent income tax return(s) (1040, 1040A, or 1040 EZ) from your spouse, dependent(s) not living in your home that you would like to and/or other adult household member(s) if filed separately.

**If you did not file for a tax return in the last year, you must submit:**

- Copy of your most recent W-2, and
- Copy of the most recent W-2(s) for your spouse, and/or other adult household member(s).

### EMPLOYEE INFORMATION

1. \_\_\_\_\_ 2. \_\_\_\_\_

Last Name                      First Name                      Middle Initial                      Employee ID

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Date of Hire (mm/dd/yyyy)                      Employee Income                      Date of Birth (mm/dd/yyyy)

6. \_\_\_\_\_

Home Address

7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City                      ZIP Code                      Preferred Phone Number

10. Write in best time to call: \_\_\_\_\_ or check one:

- 8 a.m. – 12 p.m.                       12 p.m. – 4 p.m.                       4 p.m. – 6 p.m.

### 11. REASON FOR COMPLETING FORM

Date of event: \_\_\_\_/\_\_\_\_/\_\_\_\_ (return form within 30 days of event date)

Qualifying status change (please specify):

- Open Enrollment (to ensure medical coverage, be sure you enroll in one of Ohio State's other medical coverage options during Open Enrollment while waiting to hear if you have been approved for this coverage.)
- Marriage<sup>1</sup>
- Loss of other coverage<sup>1</sup>
- Birth/Adoption/Legal guardianship/Legal custody<sup>1</sup>

<sup>1</sup>Documentation required

**FAMILY/HOUSEHOLD MEMBERS**

List the names and relationships of all household members that contribute to household income. List any dependents who do not live with you but who you would also like to enroll in medical coverage. For each person, indicate whether they currently live with you in your home and whether you wish to enroll them in medical coverage. Include the income for all household residents aged 18 or older.

**EACH COLUMN MUST BE COMPLETED**

Name	Relationship Code*	Date of Birth (mm/dd/yyyy)	Gender**	Social Security Number <sup>1</sup>	Yearly Income (of spouse or adult household residents 18+ )	Currently Live in Your Home	Enroll in OSU Medical Coverage
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

\*Use the following codes to show your relationship with the person you are enrolling in medical coverage.

Code	Relationship
SP	Spouse
C	Child

\*\*Use the following codes for gender for each person you are enrolling in medical coverage.

Code	Relationship
F	Female
M	Male

<sup>1</sup>Social security number required only for household members to enroll in Prime Care Connect.

I certify that the information on this application is complete and accurate and that all the supporting documents I have provided are valid and accurately show my current financial status. **I also understand it is my responsibility to notify the OSU Health Plan within 30 days if I have a change in financial status during the year that makes me no longer eligible for Prime Care Connect.** I understand that including false information or leaving out information on this application, or failure to inform the OSU Health Plan if I am no longer eligible for Prime Care Connect within 30 days of the change, is considered fraud. It may result in disciplinary action of an employee up to and including termination of benefits and/or employment. I also agree that the University may recover damages for all losses and reasonable attorneys' fees incurred to recover such damages.

I have read and understand the materials describing the terms and conditions of The Ohio State University Faculty and Staff Health Plan and agree to such terms and conditions. I declare that any individual for whom I am requesting health coverage as my dependent meets the definition of an eligible dependent, according to the Dependent Eligibility Guidelines, available online at [hr.osu.edu/benefits/dependent-eligibility-guidelines](http://hr.osu.edu/benefits/dependent-eligibility-guidelines). I understand that the university can stop (i.e., retroactively terminate) coverage if it was gained due to fraud. This includes an individual (or person seeking coverage on behalf of an individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact. I understand that any person who applies for coverage or files a claim containing any materially false information may be subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year (ending December 31) unless a qualifying status change occurs, as defined by the applicable plan, and the Office of Human Resources receives timely notification of such change as provided under the applicable plan. I authorize the university to deduct from my pay, on a pre-tax or after-tax basis the applicable employee contribution described in the benefit rates online at [hr.osu.edu/benefits/rates](http://hr.osu.edu/benefits/rates). I understand that this authorization to deduct employee contributions directly from my pay (i.e., a salary redirection arrangement) will remain in effect during the period of coverage and it cannot be revoked, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, if employee contributions are not paid in full, the benefits will be terminated for lack of payment, and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

**Employee Name (print)**

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**Employee Signature**

**Date**

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**Note: eligibility determination is valid only for the plan year, you must reapply annually to maintain eligibility.**

## OSU Prime Care Connect Medical Plan – Application

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### If you filed for a tax return in the last year, you must submit:

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- Copy or transcript of the most recent income tax return(s) (1040, 1040A, or 1040 EZ) from your spouse, dependent(s) not living in your home that you would like to and/or other adult household member(s) if filed separately.

### If you did not file for a tax return in the last year, you must submit:

- Copy of your most recent W-2, and
- Copy of the most recent W-2(s) for your spouse, and/or other adult household member(s).

## EMPLOYEE INFORMATION

1. Buckeye Brutus \_\_\_\_\_ 2. 12345678 \_\_\_\_\_

Last Name First Name Middle Initial Employee ID

3. 10/30/1965 \_\_\_\_\_ 4. \_\_\_\_\_ 5. 10/30/1965 \_\_\_\_\_

Date of Hire (mm/dd/yyyy) Employee Income Date of Birth (mm/dd/yyyy)

6. 281 West Lane Avenue \_\_\_\_\_

Home Address

7. Columbus \_\_\_\_\_ 8. Ohio \_\_\_\_\_ 9. (614) 292 - 6446 \_\_\_\_\_

City ZIP Code Preferred Phone Number

10. Write in best time to call: \_\_\_\_\_ or check one:

- 8 a.m. – 12 p.m.
- 12 p.m. – 4 p.m.
- 4 p.m. – 6 p.m.

### 11. REASON FOR COMPLETING FORM

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**FAMILY/HOUSEHOLD MEMBERS**

List the names and relationships of all household members that contribute to household income. List any dependents who do not live with you but who you would also like to enroll in medical coverage. For each person, indicate whether they currently live with you in your home and whether you wish to enroll them in medical coverage. Include the income for all household residents aged 18 or older.

**EACH COLUMN MUST BE COMPLETED**

Name	Relationship Code*	Date of Birth (mm/dd/yyyy)	Gender**	Social Security Number <sup>1</sup>	Yearly Income (of spouse or adult household residents 18+ )	Currently Live in Your Home	Enroll in OSU Medical Coverage
Grayson Buckeye	C	02/07/2015	M	123-45-6789	\$0	<input checked="" type="radio"/> Yes / No	<input checked="" type="radio"/> Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

\*Use the following codes to show your relationship with the person you are enrolling in medical coverage.

Code	Relationship
SP	Spouse
C	Child

\*\*Use the following codes for gender for each person you are enrolling in medical coverage.

Code	Relationship
F	Female
M	Male

<sup>1</sup>Social security number required only for household members to enroll in Prime Care Connect.



I certify that the information on this application is complete and accurate and that all the supporting documents I have provided are valid and accurately show my current financial status. **I also understand it is my responsibility to notify the OSU Health Plan within 30 days if I have a change in financial status during the year that makes me no longer eligible for Prime Care Connect.** I understand that including false information or leaving out information on this application, or failure to inform the OSU Health Plan if I am no longer eligible for Prime Care Connect within 30 days of the change, is considered fraud. It may result in disciplinary action of an employee up to and including termination of benefits and/or employment. I also agree that the University may recover damages for all losses and reasonable attorneys' fees incurred to recover such damages.

I have read and understand the materials describing the terms and conditions of The Ohio State University Faculty and Staff Health Plan and agree to such terms and conditions. I declare that any individual for whom I am requesting health coverage as my dependent meets the definition of an eligible dependent, according to the Dependent Eligibility Guidelines, available online at [hr.osu.edu/benefits/dependent-eligibility-guidelines](http://hr.osu.edu/benefits/dependent-eligibility-guidelines). I understand that the university can stop (i.e., retroactively terminate) coverage if it was gained due to fraud. This includes an individual (or person seeking coverage on behalf of an individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact. I understand that any person who applies for coverage or files a claim containing any materially false information may be subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year (ending December 31) unless a qualifying status change occurs, as defined by the applicable plan, and the Office of Human Resources receives timely notification of such change as provided under the applicable plan. I authorize the university to deduct from my pay, on a pre-tax or after-tax basis the applicable employee contribution described in the benefit rates online at [hr.osu.edu/benefits/rates](http://hr.osu.edu/benefits/rates). I understand that this authorization to deduct employee contributions directly from my pay (i.e., a salary redirection arrangement) will remain in effect during the period of coverage and it cannot be revoked, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, if employee contributions are not paid in full, the benefits will be terminated for lack of payment, and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

**Employee Name (print)**

Brutus Buckeye

**Employee Signature**

**Date**

Brutus Buckeye

11/01/2023

**Note: eligibility determination is valid only for the plan year, you must reapply annually to maintain eligibility.**

**Filing Status**  Single  Married filing jointly  Married filing separately (MFS)  Head of household (HOH)  Qualifying surviving spouse (QSS)  
 Check only one box. If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent.

Your first name and middle initial	Last name	Your social security number
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number
Home address (number and street). If you have a P.O. box, see instructions.		Apt. no.
City, town, or post office. If you have a foreign address, also complete spaces below.		State ZIP code
Foreign country name	Foreign province/state/county	Foreign postal code

**Digital Assets** At any time during 2022, did you: (a) receive (as a reward, award, or payment for property or services); or (b) sell, exchange, gift, or otherwise dispose of a digital asset (or a financial interest in a digital asset)? (see instructions.)  Yes  No

**Standard Deduction** **Someone can claim:**  You as a dependent  You as a spouse as a dependent  Spouse itemizes on a separate return or you were a dual-status alien

**Age/Blindness** You:  Were born before January 2, 1958  Are blind **Spouse:** Was born before January 2, 1958  Is blind

**Dependents** (see instructions): (4) Check the box if qualifies for (see instructions):

(1) First name	(2) Social security number	(3) Relationship to you	Child tax credit	Credit for other dependents
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

**Income**

1a Total amount from Form(s) W-2, box 1 (see instructions)	1a
b Household employer wages not reported on Form(s) W-2	1b
c Income not reported on line 1a (see instructions)	1c
d Medical waiver payments not reported on Form(s) W-2 (see instructions)	1d
e Taxable dependent care benefits from Form 2441, line 26	1e
f Employer-provided adoption benefits from Form 8839, line 29	1f
g Wages from Form 8919, line 6	1g
h Other earned income (see instructions)	1h
i Nontaxable combat pay election (see instructions)	1i
z Add lines 1a through 1h	1z

Attach Sch. B if required.

2a Tax-exempt interest	2a	b Taxable interest	2b
3a Qualified dividends	3a	b Ordinary dividends	3b
4a IRA distributions	4a	b Taxable amount	4b
5a Pensions and annuities	5a	b Taxable amount	5b
6a Social security benefits	6a	b Taxable amount	6b
c If you elect to use the lump-sum election method, check here (see instructions) <input type="checkbox"/>			
7 Capital gain or (loss). Attach Schedule D if required. If not required, check here			7
8 Other income from Schedule 1, line 10			8
9 Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your <b>total income</b>			9
10 Adjustments to income from Schedule 1, line 26			10
11 Subtract line 10 from line 9. This is your <b>adjusted gross income</b>			11
12 <b>Standard deduction or itemized deductions</b> (from Schedule A)			12
13 Qualified business income deduction from Form 8995 or Form 8995-A			13
14 Add lines 12 and 13			14
15 Subtract line 14 from line 11. If zero or less, enter -0-. This is your <b>taxable income</b>			15