

# Coverage Status Change Form

**Within 31 days of the Qualifying Event**, submit your completed form and required documentation to Student Health Insurance Office: ● [studins@ucmail.uc.edu](mailto:studins@ucmail.uc.edu)

## SECTION A: NOTICES

1. Forms submitted more than 31 days after your Qualifying Event date will not be processed.
2. You must meet the [eligibility requirements](#) to enroll in coverage.
3. You must attach documentation that verifies the Qualifying Event.
4. Approved requests to add SHI coverage are processed for the coverage period containing the Qualifying Event. Coverage will begin the date of the Qualifying Event and a fee will post to your Bursar Account.
5. Your insurance card will be available online through Catalyst, once your request has been fully processed.
6. By completing this enrollment request you are agreeing to charges on your Bursar account. For rates please visit: <https://med.uc.edu/landing-pages/studenthealth/qlc/rates>

## SECTION B: Student Information

Student M#: _____	Address: _____
Last Name: _____	Address 2: _____
First Name: _____	City: _____
Gender: _____	State: _____
Date of Birth: _____	Zip: _____
UC Email: _____	

**Mark a response for both items 1 and 2 below:**

What is your current SHI enrollment status?

- Waived- No SHI benefits
- Student Only
- Student +1 < 18
- Student +1 > 18
- Student + 2(+) < 18
- Stud + 1 > 18 + 1 < 18
- Stud + 2(+) > 18
- Stud + 1 >18 + 2(+) <18
- Stud + 3(+) >18

2. What status are you requesting?

- Student Only
- Student +1 < 18
- Student +1 > 18
- Student + 2(+) < 18
- Stud + 1 >18 +1 Dep < 18
- Student + 2(+) > 18
- Stud + 1 >18 + 2(+) <18
- Stud + 3 >18

**You must have existing SHI Coverage to add dependents.**



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## SECTION C: Qualifying Event QLE

1. What is the date of the event? \_\_\_\_\_  
 Example: Date of marriage, childbirth date, date of loss of coverage

2. Type of Event and Required Documentation: CHECK ONE

_____ Waiver canceled before waiver deadline	No documentation required
_____ I met the age limit of my other coverage.	Letter from insurance company with termination date.
_____ Because of job loss, I lost my coverage.	Letter from insurance company with termination date.
_____ Because of divorce, I lost my coverage.	Letter from insurance company with termination date.
_____ I attained eligibility after the add/drop period.	No documentation required – SHI office will verify enrollment date
_____ I have a newborn or newly adopted child.	Birth certificate or adoption document
_____ I have a new spouse.	Marriage certificate
_____ I have a dep. who newly arrived in the US.	Stamped passport or visa
_____ I was given new responsibility to insure my dep.	Legal documentation with date and requirement
_____ OTHER loss of coverage	Explain:

## SECTION D: Dependent Information

First Name	Last Name	Date of Birth	Relationship to Student	Gender

## SECTION E: Verification

My signature below verifies the following: I am requesting a change to my current SHI coverage level. I understand the notices in Section A of this form. I am providing documentation that verifies my Qualifying Event.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
 University of

