Supplemental Health Insurance – Ohio State Faculty and Staff

- This form is to be used by Ohio State faculty or staff who will be traveling on an Ohio State program with Ohio State students or undertaking travel related to international program planning for Ohio State students. It does not provide coverage for research or other university related business travel that does not involve international programs for students.
- Faculty and staff who are serving as resident directors or departmental guests traveling with an OIA administered program do not need to complete this form. They will be provided a program specific form for enrollment.

Personal Information

Last Name: ___________________________________ First Name:________________________________

Employee ID#: ________________________ Ohio State Username: ______________________ Country of Citizenship: _______________________________ Date of birth: ________/________/________

Primary Email: _____________________________ Secondary Email: _____________________________

Mailing Address: ____

Do you have a passport? ___ Yes ____ No

Passport Number: ________________________ Passport Expiration Date: _______/________/________

Trip Information

Purpose of the Travel: ____

Overseas Destination(s): ____

Departure Date from U.S.: _______/_______/_______ Return Date to U.S.: _______/_______/______

Host Institution/organization (if applicable): ____

In-country Contact Information (email and/or cell): ____

Ohio State Department Information (if a university department will pay for the insurance)

Department Contact Person: ____

Contact Person Phone: ____

Chartfield Information: ____

Release / Authorization Forms

Release of All Claims

As a condition of eligibility for participation in The Ohio State University International Travel Insurance Program or voluntary report of international independent academic activities traveling to _____________________________, I hereby agree to the following:

- I understand that if I should violate the laws and regulations of any country visited as part of this travel experience, The Ohio State University may not be held liable for such conduct if such conduct

is related to actions outside the scope of my employment responsibilities or with malicious purposes, in bad faith, or in a reckless or wanton manner. I understand that if I should confront a personal legal problem, related to actions outside the scope of my employment responsibilities, The Ohio State University cannot officially represent me or my legal interests in dealing with a foreign legal system; nor can the University assume any direct responsibility for the actions of a foreign government.

- I further understand that my participation in The Ohio State University International Travel Insurance Program does not mean that the University has necessarily approved, organized, verified, supervised, or in any way controlled any aspect of my travel. Although the university may provide general information and support to participants, I acknowledge that I am solely responsible for the conditions and risks associated with my trip, including but not limited to transportation and accommodations.

Participant's Signature: ____ Date: ____________________
Typing your name here serves as a signature

Name: ____ Date of Birth: _________/_________/________

Authorization for Emergency Medical Treatment or Surgery

- I understand that during my enrollment in Ohio State University International Travel Insurance Program illness or injury may occur that requires medical treatment, including administration of anesthetic and surgery. I further understand that a physician or medical or surgical treatment facility may require authorization to render the medical treatment and that it is my responsibility to pay any and all fees, charges, or other costs related to the medical treatment.
- Accordingly, in the event of injury or illness, if I am unable to do so myself, I authorize The Ohio State University and its agents and employees to obtain and consent to any needed medical treatment, including the administration of anesthetic and surgery, during my period of enrollment in the International Travel Insurance Program on my behalf. I also authorize the release of my appropriate medical records to attending physicians.
- Further, I agree to pay such fees, charges, and other costs that may result from the provision of such medical treatment, including treatment arranged for by the University, its agents and employees, if medical insurance provided by the program does not fully cover all such charges. I further agree to reimburse The Ohio State University, its agents and employees for any fees, charges or other costs that might reasonably incur should the University, its agents and employees be required to pay any such fees, charges or other costs incidental to the providing of such treatment on my behalf.
- I understand that the University will attempt to notify the person(s) named in the Release below in advance of any emergency medical treatment that may be required and I agree that no such advance notice is expected unless it may be practically and conveniently given. This authorization shall be effective during my enrollment in in the Ohio State University International Travel Insurance Program.

Participant's Signature: ____ Date: ___________________
Typing your name here serves as a signature

Information Release Form

The following release would permit the University to make reasonable effort to notify specified persons about your whereabouts and condition in the event that the university becomes aware of an emergency or other threat to health or safety. The second paragraph would permit the University, if an emergency occurs, to confirm or deny media reports in order to minimize the dissemination of inaccurate information and to shield your family and friends from press inquiries.

Release
In the event that The Ohio State University becomes aware of an emergency during my international travel (for example if I should suffer a physical injury or other threat to my mental or physical well-being), I hereby give permission to representatives of the University to notify the following named persons of my whereabouts and/or my condition:

Name: ____________________________ Relationship: _____________________ Phone: _______________

Name: ____________________________ Relationship: _____________________ Phone: _______________

Name: ____________________________ Relationship: _____________________ Phone: _______________

Participant's Signature: ____ Date: _____________________
Typing your name here serves as a signature

In the event that The Ohio State University becomes aware of an emergency during my international travel, I give permission to representatives of The Ohio State University to provide my name, enrollment status, and the name and location of my program of travel to the news media in order to confirm or deny to the news media information concerning my whereabouts, health and safety, and my status as a student of the University.

Participant's Signature: ____ Date: _____________________
Typing your name here serves as a signature

Department of State Information Release
In case of an emergency in which I cannot be reached, I authorize the U.S. Department of State to release information concerning my welfare and whereabouts to representatives of The Ohio State University.

Participant's Signature: ____ Date: _____________________
Typing your name here serves as a signature

Payment information
The supplemental travel insurance is $1.50 per day for enrollees up to age of 74. The total premium will be calculated using the daily rate multiplied by the number of days between the departure date and return date listed in the trip information. This calculation will include the departure date and the return date as days of coverage. Please indicate your preferred method of payment/charge assessment. Your application for the supplemental travel insurance will not be processed without proper payment.
____ I am including a personal check or money order made payable to The Ohio State University with this form.
____ My department is paying for my insurance, please see Department Information section of this form.

Please return completed form with payment or payment information to:
Laurie Ogburn
Office of International Affairs
186 Enarson Classroom Building
2009 Millikin Road
Columbus, OH 43210

Questions may be directed to Laurie Ogburn at ogburn.4@osu.edu.