DEPENDENT REGISTRATION AND FINANCIAL AGREEMENT FOR ACCESS TO WILCE PHARMACY

Ohio State Students: Use this form to register your dependent(s) to have their prescriptions filled at the Student Health Services Pharmacy located within the Wilce Student Health Center. Co-pay or co-insurance amounts are due at the time of service. If you are not covered by a participating prescription plan or have not paid your Student Health Insurance premium in full, then payment in full is required prior to receipt of the medication.

Please print and provide all requested information.

Student Information

Last Name:	First Name & Middle Initial:	OSU Student ID Number:
Street Address, City, State, Zip Code:		
Email:	Telephone:	Date of Birth:

Dependent Information

A Dependent is:

1. The student's legal spouse;
2. The student's same- or opposite-sex domestic partner;
3. The student's unmarried children. The term "children" includes a student's biological children; stepchildren; foster children; adopted children from the date of placement in the student's home and who depend on the student for their support; children which the student has been granted legal custody; children which the student has legal obligation to provide coverage due to a court order; and children of the student's domestic partner.

Has the dependent(s) ever been a student of The Ohio State University?____________
Dependent's former name?_______________

Student? (Y/N)	Last Name:	First Name:	Relationship:	Sex:	Date of Birth:

STUDENT PLEASE READ CAREFULLY AND SIGN:

I understand I am fully and solely responsible for any and all debts incurred by my legal spouse, domestic partner, and/or dependent children at the Wilce Student Health Center Pharmacy. Failure to pay any co-payments, co-insurance, uncovered expenses, or any other expenses will result in collection efforts including, but not limited to, placing a hold on all Ohio State accounts, records, registration, and graduation. I understand that any false statement or misrepresentation made on this form will result in loss of coverage under the Ohio State Student Health Insurance Plan and/or access to Wilce Pharmacy if covered by another insurance plan or not insured. In addition, I authorize the release of any and all information for processing claims for my minor dependents (17 years of age or younger).

Student signature ____________________________________Date ________________________

SPOUSE/PARTNER AND/OR CHILDREN 18 YEARS OF AGE OR OLDER, PLEASE READ AND SIGN:

I authorize release of any and all information for processing of claims/charges.

Signature____Date________________________

For Office Use Only

AU__:_____ WI__:_____ SP__:_____ SU__:_____ Date____ By_____