STUDENT INSURANCE PLANS
2013-2014

ENROLLMENT FORM

Please complete, sign, and return the enrollment form to:

THE UNIVERSITY OF IOWA
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING
IOWA CITY, IOWA  52242-1911

You will be billed monthly through The University of Iowa student billing system or bank account, if appropriate.

AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage myself and for all persons named in this enrollment form. I understand that I am making application for the coverage sponsored by The University of Iowa, offered by Wellmark, Inc., doing business as Blue Cross and Blue Shield of Iowa and by Delta Dental of Iowa.

I certify that, after this enrollment form was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Wellmark Blue Cross and Blue Shield of Iowa and Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statement made, and that if I have made any fraudulent statements, or have intentionally misrepresented any material fact, Wellmark Blue Cross and Blue Shield of Iowa or Delta Dental of Iowa will be entitled to declare the contract applied for void and to refuse allowance of benefits to any person thereunder.

I authorize any provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa and Delta Dental of Iowa when reasonably related to the care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

The University of Iowa is hereby authorized to charge my University bill or bank account, as appropriate, for the premium. I understand that if the University bill on which the premium first appears is not paid when due, the coverage may be canceled.
**EMPLOYED GRADUATE STUDENT INSURANCE APPLICATION**

**PART 1: ACTION REQUESTED**

Select your enrollment type: [ ] NEW APPLICATION  [ ] CHANGE  [ ] ADD DEPENDENT(S)

Reason for this action: [ ] MARRIED  [ ] BIRTH  [ ] DIVORCE  [ ] DEATH  [ ] OTHER — explain:

**PART 2: YOUR INFORMATION**

Social Security #: or University ID#:

Full Name (L, F, MI):  Sex (M/F):  Date of Birth:

Residing Address:  City:  State:  ZIP Code:

Telephone Number: ( )  E-mail:

**PART 3: HEALTH INSURANCE**

Select your health plan: [ ] SHIP  [ ] UIGRADCare

[ ] ENROLL me in Health Insurance  [ ] CHANGE my Health Insurance  [ ] CANCEL my Health Insurance

**PART 4: DENTAL INSURANCE**

Select your dental plan: [ ] Student Dental Insurance

[ ] ENROLL me in Dental Insurance  [ ] CANCEL my Dental Insurance

**PART 5: DEPENDENT INFORMATION:**

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>(First)</th>
<th>(M.I)</th>
<th>Relationship (use codes above)</th>
<th>Sex (M/F)</th>
<th>Birthdate (MM/DD/YY)</th>
<th>Social Security #</th>
<th>Health</th>
<th>Dental</th>
</tr>
</thead>
</table>

S-spouse  D-Domestic Partner  C-Child

[ ] SPOUSE IS A UNIVERSITY OF IOWA STUDENT  [ ] SPOUSE IN GRAD STUDNT W/ASSISTANTSHIP

**PART 6: AGREEMENT AND CERTIFICATION**

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer. I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the premiums. This authorization is to remain in effect until the employer is notified by me. I understand that this coverage for the health care contracts applied for will not start until after this application is received and accepted by the Plans and an effective date is established by the Plans. I understand that written notice of rate changes will be furnished by my employer. I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Plans will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any fraudulent statements or intentional misrepresentations of any material fact, the Plans will be entitled to declare the health care contracts applied for void and to refuse allowance of benefits to any person thereunder. I authorize any health care provider to release medical records to the Plans when reasonably related to the health care coverage for which I have applied. If any law or regulation requires additional information for release of medical records, I will give this authorization.

Date:  Signature (Please sign your name as completed in PART 2 above. DO NOT PRINT)

**RETURN FORM TO:**

University Benefits, 120 University Services Bldg., Iowa City, IA 52242-1911  Fax: 319-335-2776, e-mail: benefits@uiowa.edu