



UNPAID J-1 SCHOLARS ENROLLMENT FORM

ABOUT THIS FORM

This form is required for all unpaid J-1 scholars and their J-2 dependents to enroll in the University of Iowa–sponsored health and dental insurance plans. Completing this form ensures you meet federal J-1 visa requirements and maintain access to essential health benefits during your program.

Instructions for Completion

Please complete all sections of this form as accurately as possible. Review the Agreement and Certification statement carefully before signing. Incomplete or incorrect information may delay your enrollment.

Where to Submit

After completing and signing the form, return it to International Student & Scholar Services (ISSS) at:
1111 University Capitol Centre, Iowa City, IA 52242-5500
Email: iss@uiowa.edu
Fax: 319-335-0280

Billing Information

You will be billed monthly through the University of Iowa student billing system or your 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 intentional misrepresentations of 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.



UNPAID J-1 and J-2 FAMILY MEMBERS ENROLLMENT FORM

PART 1: YOUR INFORMATION

Full Name (Last, First, Middle Initial):

University ID:

Date of Birth:

Sex (Male/Female):

Current Address (Street, City, State, Zip Code):

Phone Number:

E-mail:

PART 2: CHOOSE YOUR COVERAGE AND REQUESTED ACTION

Select Health Plan: Student Health Plan (SHIP) UIChoice UISelect Requested Action: Enroll Change

Dental Plan (Student Dental or Dental II):

Note: If enrolling, your dental plan must match your health plan category. You may not enroll in the Student Health Insurance Plan and the employee Dental II plan together.

Requested Action: Enroll Cancel

PART 3: DEPENDENT INFORMATION

Spouse/Partner Name (Last, First, Middle Initial)	Sex (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Health	Dental
Dependent Child Name (Last, First, Middle Initial)	Sex (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Health	Dental
Dependent Child Name (Last, First, Middle Initial)	Sex (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Health	Dental
Dependent Child Name (Last, First, Middle Initial)	Sex (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Health	Dental

PART 4: AGREEMENT AND CERTIFICATION

I have read and understand the agreement and certification language on the previous page of this enrollment form.

Signature (DO NOT PRINT):

Date:

Return Form To: ISSS 1111 UCC, Iowa City, IA 52242 Email: iss@uiowa.edu Fax: 319-335-0280	Effective Date ____ / 01 / 20____	ISSS Approval Initials: _____ MFK:
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