DEPARTING STUDENT INSURANCE PLANS
2017-2018

ENROLLMENT FORM
Please complete, sign, and return this enrollment form to:

UNIVERSITY OF IOWA
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING
IOWA CITY, IOWA  52242-1911
FAX:  319-335-2776

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 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.

(Visit the next page)
DEPARTING STUDENT ENROLLMENT FORM

PART 1: ENROLLMENT BEGINNING DATE

Coverage will begin the first day of the month following your departure from the University of Iowa.

□ 09/01/2017  □ 01/01/2018  □ 06/01/2018  □ Other: ___ / ___ / ___

PART 2: YOUR INFORMATION

Full Name (Last, First, Middle Initial): ____________________________________________

University ID Number (8 digits): __________________________ Date of Birth: ____________ Sex (M/F): __________

Residing Address, City, State & Zip Code: _________________________________________

Telephone Number: ___________________________ E-mail: ___________________________

PART 3: HEALTH INSURANCE

Select your health plan:  □  SHIP

□ ENROLL me in 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

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<th>NAME:</th>
<th>Last, First, Middle Initial</th>
<th>Relationship Code</th>
<th>Sex (M/F)</th>
<th>Birthdate (MM/DD/YY)</th>
<th>Social Security #</th>
<th>Health</th>
<th>Dental</th>
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PART 6: OPTIONAL ACH AUTHORIZATION

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU WISH TO HAVE YOUR HEALTH INSURANCE PREMIUMS DEDUCTED FROM A CHECKING ACCOUNT RATHER THAN BILLED TO YOUR UNIVERSITY BILL. AUTHORIZATION FOR PRE-AUTHORIZED PAYMENTS OF STUDENT HEALTH INSURANCE PLAN PREMIUMS TO BE PAID TO THE UNIVERSITY OF IOWA.

I HEREBY AUTHORIZE THE UNIVERSITY OF IOWA TO INITIATE DEBIT ENTRIES TO MY ACCOUNT INDICATED BELOW AND THE FINANCIAL INSTITUTION NAMED BELOW. HEREINAFTER TO DEBIT THE SAME TO SUCH ACCOUNT.

The University of Iowa requests this information for the purpose of establishing the payment of your Student Health Insurance Plan premiums. Individuals outside the University employed by the institution who will administer this benefit will have access to this information. No other persons outside the University are routinely provided this information. If you fail to provide the required information, the University cannot authorize the direct payment from your institution to the University of your health insurance premiums. (PLEASE ATTACH A VOIDED CHECK OR OTHER DOCUMENT CONTAINING THE INFORMATION BELOW)

FINANCIAL INSTITUTION: __________________________ ADDRESS: __________________________

CITY, STATE: __________________________ TRANSIT/ABA NUMBER: ___ OR ___ DIGIT #

YOUR ACCOUNT NUMBER: __________________________ □ CHECKING □ SAVINGS

SIGNATURE OF ACCOUNT HOLDER: __________________________ DATE: __________________________

PART 7: AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification language on the back of this form.

Student’s Signature: __________________________________________ Date: ________________

Return Form To: University Benefits Office, 120 University Services Bldg., Iowa City, IA 52242;

e-mail: benefits-Students@uiowa.edu; fax: 319-335-2776

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For Benefits Use: [008-00876]