EMPLOYED GRADUATE STUDENT INSURANCE PLANS

2016-2017

ENROLLMENT FORM

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

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.

(visit the next page)
EMPLOYED GRADUATE STUDENT ENROLLMENT FORM

PART 1: ACTION REQUESTED

► If you are enrolling outside the open enrollment period, your coverage will begin the first day of the month following the receipt of your enrollment form. **What month would you like your coverage to take EFFECT?  ____ / 01 / 20**

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

Reason for this action: □ OPEN ENROLLMENT □ DIVORCE □ LOSS OF COVERAGE

Date of event: □ MARRIAGE □ BIRTH

Other: (explain):

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 □ UIGRADCare

□ ENROLL me in Health Insurance

□ CHANGE my Health Insurance

□ CANCEL my Health Insurance

PART 4: DENTAL INSURANCE

□ ENROLL me in Dental Insurance

□ CANCEL my Dental Insurance

To change a dependents’ coverage, check the boxes below:

□ ADD □ DROP ----------- □ HEALTH □ DENTAL

Dependent(s):

PART 5: DEPENDENT INFORMATION

(Name: Last, First, Middle Initial)

Relation Code Sex (M/F) Birthdate (MM/DD/YY) Social Security # Health Dental

NAME: Last, First, Middle Initial

NAME: Last, First, Middle Initial

NAME: Last, First, Middle Initial

NAME: Last, First, Middle Initial

Please check if either applies to your spouse:

□ Spouse is a University of Iowa Student □ Spouse is a Grad Student with Assistantship

OUT OF AREA: Please fill out this section if you and/or your dependents will be out of the area for 30 days or more.

Employee/Dependent(s): Location and Dates, if Out of Area:

PART 6: AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification language on the previous page.

Signature (DO NOT PRINT): ______________________________ Date: __________________

Return Form To: University Benefits Office, 120 University Services Bldg., Iowa City, IA 52242; e-mail: benefits@uiowa.edu; fax: 319-335-2776

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For Benefits Use: [008-00876]