☐ SPOUSE IS GRADUATE STUDENT W/ASSISTANTSHIP

EMPLOYED GRADUATE STUDENT INSURANCE APPLICATION

☐ NEW/RENEW APPLICATION ☐ CHANGE APPLICATION

EFFECTIVE DATE
_____|_____|_____
MUST COMPLETE
(SEE BROCHURE)

A. NAME, ADDRESS AND COVERAGE

1. NAME (LAST) (FIRST) (MIDDLE INITIAL)	TELEPHONE NO. ( )	SOCIAL SECURITY #	BIRTH DATE

2. RESIDENCE (NO) (STREET OR RFD #) (APT #) (CITY) (STATE) (ZIP)	SEX ☐ MALE ☐ FEMALE

3. EMPLOYER NAME
THE UNIVERSITY OF IOWA

4. CIRCLE HEALTH AND/OR DENTAL PLAN
SHIP **UIGRADCare** **DENTAL**

B. CONTRACT INFORMATION

(COMPLETE ONLY IF YOU ARE COVERING SPOUSE, DOMESTIC PARTNER, OR CHILDREN)

Mark for each person HEALTH	DENTAL	NAME (LAST) (FIRST) (INITIAL)	BIRTH DATE MO DAY YEAR	UI STUDENT	SEX	SOCIAL SECURITY #
☐	☐	(SPOUSE)		☐ YES ☐ NO	☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ MALE ☐ FEMALE	

5. OCCURRENCES AFFECTING CONTRACT BENEFITS ☐ MARRIED ☐ SINGLE ☐ BIRTH ☐ DEATH ☐ OTHER—explain:	NAME OF AFFECTED PARTY	DATE OF EVENT

C. UIGRADCare PROVIDER SELECTION

Students, spouses, and dependents must choose a primary care clinic. Females may designate a separate OB/GYN clinic.

Employee/Dependent(s)	Location, If Out of Area	Clinic

D. 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 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 false statements or misrepresentations, or have failed to disclose or concealed 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 A above.)
DO NOT PRINT

Return to: University Benefits Office, 120 University Services Bldg., Suite 40, Iowa City, IA 52242-1911

008-00870