☐ SPOUSE IS GRADUATE STUDENT W/ASSISTANTSHIP

☐ NEW APPLICATION ☐ CHANGE

EMPLOYED GRADUATE STUDENT INSURANCE 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)	BIRTHDATE MO DAY YEAR	UI STUDENT	FULL-TIME STUDENT	SEX	SOCIAL SECURITY #
☐	☐	(SPOUSE)		☐ YES ☐ NO		☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ YES ☐ NO	☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ YES ☐ NO	☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ YES ☐ NO	☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ YES ☐ NO	☐ MALE ☐ FEMALE	
☐	☐	(CHILD)			☐ YES ☐ NO	☐ MALE ☐ FEMALE	

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

C. UIGRADCare OUT OF AREA

Please complete the section below only if you and/or your dependents will be out of the area for 90 days or more.

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

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 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 A above.)**

DO NOT PRINT

Return to:
University Benefits, 120 University Services Bldg, Suite 40, Iowa City, IA 52242-1911
Fax: (319) 335-2776
e-mail: benefits@uiowa.edu