
**STUDENT INSURANCE PLANS
2009 - 2010**

ENROLLMENT FORM

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

**THE UNIVERSITY OF IOWA
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING SUITE 40
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 false statements or misrepresentations, or have failed to disclose or conceal 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.

THE UNIVERSITY OF IOWA

New/Renew _____ Change _____

ENROLLMENT FORM

PLEASE PRINT:

Student Name (Last, First, MI) Sex M F

Birth Date (month/day/year) Social Security Number

Local Address (Home or Office)

City, State, Zip

Telephone Number

Insurance Plans: SHIP Dental

Enrollment Beginning Date:

08/01/2009 01/01/2010 05/01/2010
 09/01/2009 02/01/2010 06/01/2010

Contract Information: Coverage is for (check one):

- Student
 Student & Spouse/Domestic Partner
 Student & Children
 Student, Spouse/Domestic Partner, & Children

List dependents below: (Complete this section only if you are covering your spouse, domestic partner or children.)

Spouse/Domestic Partner Name (Last, First, MI) Sex M F

Birth Date (month/day/year) Social Security Number
Coverage SHIP Dental

Child Name Sex M F

Birth Date (month/day/year) Social Security Number
Coverage SHIP Dental Fulltime Student Yes No

Child Name Sex M F

Birth Date (month/day/year) Social Security Number
Coverage SHIP Dental Fulltime Student Yes No

Child Name Sex M F

Birth Date (month/day/year) Social Security Number
Coverage SHIP Dental Fulltime Student Yes No

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

Student's Signature

Date

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU WISH TO HAVE YOUR HEALTH INSURANCE PREMIUMS DEDUCTED FROM A CHECKING OR SAVINGS ACCOUNT RATHER THAN BILLED TO YOUR UNIVERSITY BILL AUTHORIZATION AGREEMENT 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 (8 OR 9 DIGIT NUMBER ON BOTTOM OF CHECK)

YOUR ACCOUNT NUMBER: _____
 Checking Savings

SIGNATURE OF ACCOUNT HOLDER

DATE

Return to:

University Benefits Office
120 University Services Building, Suite 40
Iowa City, IA 52242-1911