Iowa State University
Visiting Scholar Health Insurance Form
Extension of Stay

1. **Department MUST Complete:** This form will NOT be processed without this section completed

Billing Option: ☐Visiting Scholar – billed via U-bill ☐ Department – billed via intramural

Department _____ Department Contact _____

Fund Account or Worktag: _____

*(*Fund Account or Worktags must be obtained/filled out by Department)*

(Please note: Department guarantees any unpaid VS premium balances)

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2. **Scholar MUST complete:**

Extension start date: _____ ***ISU Program End Date:** _____

Family/Last Name _____ Given/First Name _____

Email Address: _____

University ID number _____

* §62.14 Insurance: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1bc531bf257789e45b3049bff8b50d64&r=PART&n=22y1.0.1.7.35#se22.1.62_114

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3. **Monthly Premiums for 2024 - 2025 Plan Year** *(check one)*:

☐Scholar Only: **$290.00 per month** ($249.00 insurance premium + $41.00 health facility fee)

☐Scholar & Spouse/Domestic Partner: **$607.00 per month** ($525.00 insurance premium + $82.00 health facility fee)

☐Scholar & Child(ren): **$516.00 per month** ($475.00 insurance premium + $41.00 health facility fee)

☐Scholar, Spouse/Domestic Partner & Child(ren): **$833.00 per month** ($751.00 insurance premium + $82.00 health facility fee)

Your University Bill will be billed for your entire stay or a few months at a time based on the length of your stay.
Monthly premiums are not pro-rated for less than a month's coverage.
Example: arrival date of January 20 and departure date of February 15 – total you will be billed is for 2 monthly payments.

4. **List All Covered Dependents:** *(Dependent coverage is only available if the scholar is covered)*

Dependents	Last Name	First Name	Date of Birth	Gender (M/F)
Spouse/ Domestic Partner				
Child				
Child				
Child				

5. **Agreement/Certification:** The premium rates shown above are for the insurance period from August 1, 2024 through July 31, 2025.

- I understand that deductibles and co-pays are calculated on an annual basis starting August 1st of each year.
- 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/Blue Shield 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 conceal any material fact, Wellmark BC/BS will be entitled to declare the health care contracts applied for void, and to refuse allowance of benefits to any person there under.
- I authorize any health care provider to release medical records to Wellmark BC/BS when reasonably related to the health care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

Scholar Signature: _____ Date: _____

SSHIP-VSEnroll

Office Use Only
BE ____ SS____
Copy to Acctg _____ Processed by _____