# Iowa State University
## Student and Scholar Insurance Form

**Application for** ___ Enrollment ___ Add dependent (*to student's existing plan)*
___ Drop Coverage due to Qualifying Event for: _____ Self ____ Dependent
Name of Dependent:_____

**Qualifying Event** ____ New Student ____ New Graduate Assistant Appointment
____ Loss of Coverage ___ Birth ___ Marriage ___ Arriving in the US ___ Departing from the US
____ Newly eligible for other coverage Other _____

**Date of Qualifying Event** _____ ***Please provide proof of the qualifying event***

*Please check if you want Health Insurance and/or Dental Insurance* ***and*** *level of coverage*

☐ **Health Insurance** ☐ Self ☐ Self & Spouse (Sp)/Domestic Partner (DP) ☐ Self & Child(ren) ☐ Self, Sp/DP & Child(ren)
☐ No Coverage *(*not available to International Students)* ☐ Drop with a Qualifying Event

☐ **Dental Insurance** ☐ Self ☐ Self & Spouse (Sp)/Domestic Partner (DP) ☐ Self & Child(ren) ☐ Self, Sp/DP & Child(ren)
☐ No Coverage *** Drop - dental *insurance cannot be dropped during the plan year***

**University ID Number** _____ **Social Security Number**_____

**Last Name** _____ **First Name**_____

Address during plan year _____

Date of Birth *(month/day/year)* _____ Gender ____ Male ____ Female

___ **Undergraduate or Graduate Student**
Premiums billed to University bill

___ **Graduate Assistant**
Dental and dependent premiums will be deducted through payroll

**List All Covered Dependents:** *Complete this section only if you are covering your spouse, domestic partner or child(ren).*
** Declaration of Domestic Relationship must be completed when adding a spouse/domestic partner.*

| | Social Security Number or indicate Foreign National *(FN)* | **Name** *(Last, First, Middle Initial)* | **Birth Date** *(month/day/year)* | M/F Gender | Health | Dental |
|---|---|---|---|---|---|---|
| Spouse/Partner* | | | | | | |
| Child | | | | | | |
| Child | | | | | | |
| Child | | | | | | |

**Spouse/Partner – please complete the Domestic Relationship form. An additional Health Fee will be charged to the student's university bill**

Disclosure of your social security number (SSN) is requested from you in order for Iowa State University (ISU) to administer benefits. The IRS requires Wellmark Blue Cross & Blue Shield to report and send the information needed to complete federal tax returns using the Social Security number or tax identification number of the plan member and each dependent. Federal and State law protects the privacy and security of your SSN and ISU will not disclose your SSN without your consent for any other purposes except as allowed by law. ISU is working to minimize the use of SSN's within its business processes.

**Other Insurance coverage:** No ___ Yes ___ If you will be covered under another health or dental plan while on the SSHIP coverage please provide a copy of that insurance card so coordination of benefits can be setup by Wellmark Blue Cross & Blue Shield or Delta Dental.

**Agreement/Certifications:**

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 coverage sponsored by Iowa State University, underwritten by Wellmark Blue Cross and Blue Shield & 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 Insurance Companies 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 have concealed any material fact, the Insurance Companies will be entitled to declare this contract applied for void, and to refuse allowance of benefits to any person thereunder.

I authorize any health care & dental provider to release Health records to Wellmark Blue Cross & Blue Shield Life Insurance Company or 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 Health records, I will give this authorization.

I have read and understand the Agreement and Certification language on the back of this form. Your signature authorizes ISU to add the Health and/or Dental Premiums to your fees.

Signature_____ Date _____

**Return completed form to**: **ISU SSHIP Office, 1218 Madden Building, 2221 Wanda Daley Drive, Ames IA 50011-1004**
**Fax:** 515.294.8226 **Email:** isusship@iastate.edu

SSHIP-MDEnroll

*Office Use Only* QE Verified ____
UG/G: Class Credits _____ BE ____
GA: Workday/LOI _____ BE _____
Refunds: Cybox SS _____ Amt _____