

Iowa State University

Student and Scholar Insurance Form

Application for	<input type="checkbox"/> Enrollment <input type="checkbox"/> Add dependent (<i>to student's existing plan</i>) <input type="checkbox"/> Drop Coverage due to Qualifying Event for: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Name of Dependent: _____
Qualifying Event	<input type="checkbox"/> New Student <input type="checkbox"/> New Semester <input type="checkbox"/> New Graduate Assistant Appointment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Arriving in the US <input type="checkbox"/> Departing from the US <input type="checkbox"/> Newly eligible for other coverage Other _____
Date of Qualifying Event _____	<i>Please provide proof of the qualifying event</i>

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	Health	Dental
				Gender		
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: Iowa State University Service Center, 3810 Beardshear Hall 515 Morrill Road Ames IA 50011-2103
 Fax: 515.294.8226 Email: isusship@iastate.edu

