Iowa State University
Visiting Scholar Health Insurance Form

Change in Enrollment for Visiting Scholar

Visiting Scholar Info:

University ID number __________________________________________________________

Last Name _____________________________________  First Name ________________________________________

Drop:  Provide copy of airline ticket(s) OR other supporting documentation  Date of Event _______________________

☐ My Departure from USA  ☐ Drop Family Member  Reason: _________________________________________

Name of Family Member(s) dropping _____________________________________________

Add:  Provide copy of Passport OR other supporting documentation  Date of Event___________________________

☐ Add Family member  Reason: ☐ Arrival in the USA  ☐ Birth  ☐ Other _________________________________

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

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<tr>
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<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Gender (M/F)</th>
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<td>Spouse/Domestic Partner</td>
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New Premium and Enrollment coverage is for (check one):

☐ Self Only  $194.00 per month  =  $167.00 insurance premium + $27.00 health facility fee
☐ Self & Spouse/Domestic Partner  $406.00 per month  =  $352.00 insurance premium + $54.00 health facility fee
☐ Self & Child(ren)  $345.00 per month  =  $318.00 insurance premium + $27.00 health facility fee
☐ Self, Spouse/Domestic Partner & Child(ren)  $557.00 per month  =  $503.00 insurance premium + 54.00 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.

Agreement/Certification:
The premium rates shown above are for the insurance period from August 1, 2018 through July 31, 2019.  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 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 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:____________________