STUDENT INSURANCE PLANS
(SHIP)

DEPARTING STUDENTS
ENROLLMENT FORM

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

University of Northern Iowa
Student Health Clinic Insurance Office
Cedar Falls, IA  50614-0221
Fax: (319) 273-7030

You will be billed monthly through the University of Iowa 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 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 fraudulent statements or intentional misrepresentations, of 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 health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa 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 medical records, I will give this authorization.

The University of Iowa is hereby authorized to bill the contract holder directly or bank account, as appropriate, for the premium. I understand that if the University of Iowa bill on which the premium first appears is not paid when due, the coverage may be canceled.

(Visit the next page)
### PART 1: ENROLLMENT BEGINNING DATE

- 09/01
- 01/01
- 06/01

### PART 2: YOUR INFORMATION

- Social Security #: [ ]
- AND [ ]
- University ID#: [ ]

- Full Name (Last, First, Middle Initial): [ ]
- Sex (M/F): [ ]
- Date of Birth: [ ]

- Billing Address: [ ]
  - City: [ ]
  - State: [ ]
  - ZIP Code: [ ]

- Telephone Number: [ ]
  - E-mail: [ ]

### PART 3: HEALTH INSURANCE

- Select your health plan: [ ] SHIP

- ENROLL me in Health Insurance
- CANCEL my Health Insurance

### PART 4: DENTAL INSURANCE

- Select your dental plan: [ ] Student Dental Insurance

- ENROLL me in Dental Insurance
- CANCEL my Dental Insurance

### PART 5: DEPENDENT INFORMATION:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship (use codes above)</th>
<th>Sex (M/F)</th>
<th>Birthdate (MM/DD/YY)</th>
<th>Social Security #</th>
<th>Health</th>
<th>Dental</th>
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### PART 6: (OPTIONAL) ACH AUTHORIZATION

- FINANCIAL INSTITUTION: [ ]
- ADDRESS: [ ]
- CITY, STATE: [ ]
- TRANSIT/ABA NUMBER: [ ]
- YOUR ACCOUNT NUMBER: [ ]
- CHECKING [ ] SAVINGS [ ]
- SIGNATURE OF ACCOUNT HOLDER: [ ]
- DATE: [ ]

### PART 7: AGREEMENT AND CERTIFICATION

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

Students Signature: [ ]
- Date: [ ]