STUDENT HEALTH INSURANCE PLAN  
(SHIP)  

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  

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 and 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 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.
STUDENT ENROLLMENT FORM

PART 1: ENROLLMENT BEGINNING DATE

☐ 08/01  ☐ 01/01  ☐ 05/01
☐ 09/01  ☐ 02/01  ☐ 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:

Name (Last)                                    (First)                    (M.I)

Relationship (use codes above)

Sex (M/F)  Birthdate (MM/DD/YY)  Social Security #  Health  Dental

PART 6: OPTIONAL ACH AUTHORIZATION

I HEREBY AUTHORIZE THE UNIVERSITY OF IOWA TO INITIATE DEBIT ENTRIES TO MY ACCOUNT INDICATED BELOW AND THE FINANCIAL INSTITUTION NAMED BELOW. HERINAFTER TO DEBIT THE SAME TO SUCH ACCOUNT.

The University requests this information for the purpose of establishing the payment of your Student Health Insurance Plan premiums. Individuals outside the University employed by the institution who will administer this benefit will have access to this information. No other persons outside the University are routinely provided this information. If you fail to provide the required information, the University cannot authorize the direct payment from your institution to the University of your health insurance premiums.

(PLEASE ATTACH A VOIED CHECK OR OTHER DOCUMENT CONTAINING THE INFORMATION BELOW)

FINANCIAL INSTITUTION:  ADDRESS:  CITY, STATE:

TRANSIT/ABA NUMBER:  8 OR 9 DIGIT # ON BOTTOM OF CHECK  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:

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

If you are enrolling outside the open enrollment period, your coverage will begin the first day of the month following the receipt of your application. Other Enrollment Date:  01 / 20