

Student Health Insurance Plan (SHIP) Enrollment Form for Affordable Care Act (ACA) Health Insurance

A. Student Employee Information – If you are waiving coverage please do not add social security number to this form. (Record legal last and first name as it appears on Social Security Card.)					
Social Security Number			University ID #		
	<u>AND</u>				
Name (Last, First, MI): Gender (M/F): Birthdate:					ate:
Street Address 1 ^a : Street Address 2 ^a :					
City: State:	Zip:			Email:	
Telephone Number: a UNI data systems are limited to 25 characters.					
B. Health Insurance					
Health Coverage Selected: SHIP ACA Waiver of Enrollment: ☐ Self (\$103.00 monthly or \$1,236.00 Annually) ☐ Self & Child(ren) (\$365 monthly or \$4,380 Annually)					
C. Dependent Information					
Dependents List Name (Last, First, MI) (Record legal last and first name)		Gender		Birthdate	Social Security Number
			□F		
			□ F		
			□ F		
			□ F		
D. Agreement and Certification	L	M	□F		
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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.					
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 lowa 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 lowa 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 Wellm care for which I have applied. If any law or regulation require authorization.					
The University of Northern Iowa is hereby authorized to bill	the contract ho	lder di	rectly	onto their universit	y bill for the premium.
If you have read and understand the Agreement and Certification language above, please sign below:					
gnature: Date Signed:					
This area to be completed by Career Services					
Health Group No Effective Date: Tentative Coverage End Date:					
☐ ACA New Hire Eligibility ☐ ACA Change in Hours Eligibility	/ ACA Sta	andard l	Measu	rement Period	ACA Initial Measurement Period

Revised 07/2023