University of Northern Iowa

Human Resource Services

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 ☐☐☐ - ☐☐ - ☐☐☐☐ **AND** **University ID #** ☐☐☐☐☐☐

Name (Last, First, MI): _____ **Gender (M/F):** _____ **Birthdate:** _____

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

☐ Self ($101.00 or $1,212.00 Annually)

☐ Self & Child(ren) ($386 or $4,632 Annually)

Waiver of Enrollment:

☐ I waive health coverage for my dependents and myself.

C. Dependent Information

Dependents List Name (Last, First, MI) (Record legal last and first name)	**Gender**		**Birthdate**	**Social Security Number**
	☐ M	☐ F		
	☐ M	☐ F		
	☐ M	☐ F		
	☐ M	☐ F		
	☐ M	☐ F		

D. 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.

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 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 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 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 Northern Iowa is hereby authorized to bill the contract holder directly onto their university bill for the premium.

If you have read and understand the Agreement and Certification language above, please sign below:

Signature: _____ **Date Signed:** _____

This area to be completed by the UNI Student Health Clinic

Health Group No. _____ Effective Date: _____ Tentative Coverage End Date: _____

Completed forms must be returned to the UNI Student Health Clinic
1227 W 27th Street
Building 0221
Cedar Falls, Iowa 50614-0221