

University of Delaware Student Accident & Sickness Insurance Application

YES - I do want the University of Delaware Student Health Insurance Program for U.S. Citizens and Permanent Resident Immigrants

A. PERSONAL INFORMATION (Please Print)

LAST NAME, FIRST NAME, MIDDLE INITIAL _____

UNIVERSITY OF DELAWARE ID NUMBER _____

SEX - Circle One

DATE OF BIRTH _____

STATUS - Check One

M / F _____

Non-Funded Graduate

Funded Graduate¹

Undergraduate Student

HOME ADDRESS - Street, City, State, Zip Code _____

E-mail address: _____

Are you or any family members covered by other health insurance? (circle one)

YES / NO

If Yes, please complete the following:

Name of Insurance Company _____

Address of where claims are submitted to: _____

Is this an Employer Policy? Yes / No

If Yes, Employer Name: _____

Name of Policyholder _____

Policy Identification Number _____

Effective Date of Policy _____

Who is covered? Circle all that are applicable:

Student / Spouse / Dependent Child(ren)

C. INDIVIDUALS TO BE COVERED

Eligible Dependents Definition:

Dependents must be born to you or your spouse or legally adopted, under age of 19 and unmarried, and dependent on you for support as defined by the Internal Revenue Service (IRS)

Spouse's First Name _____

M.I. _____

Spouse's Last Name - if different _____

Date of Birth _____

Sex _____

Dependent's First Name _____

M.I. _____

Dependent's Last Name - if different _____

Date of Birth _____

Sex _____

Dependent's First Name _____

M.I. _____

Dependent's Last Name - if different _____

Date of Birth _____

Sex _____

D. TERMS OF AGREEMENT

* My application is subject to acceptance by Nationwide Life Insurance Company.

* I authorize any physician, hospital and or any other health care provider to release information available to them as to diagnosis, treatment or any other health care services they render to me or my covered dependents to the Nationwide Life Insurance Company or their legal representative.

* I also authorize Nationwide Life Insurance Company to release appropriate diagnostic and medical information to other persons in connection with a claim for coordination of benefits or other purposes related to this contract.

* I am being offered Plan Blue and Plan Blue and Gold health insurance from the Nationwide Life Insurance Company and have chosen the plan appropriate for my needs.

* I understand that if my application is accepted my coverage will end on the end date which I selected and I will be responsible for any continued coverage after the end date.

* I certify that I am an admitted University of Delaware student as of the date of this application.

SIGNATURE OF APPLICANT _____

(BACK OF APPLICATION MUST BE COMPLETED)

DATE OF APPLICATION - Month, Day, Year _____

X _____

Foreign students holding F1 and J1 Visas are not to use this application form.

Return completed application by coverage start date to:

**University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454**

¹ Graduate student receiving stipend and/or tuition from the University of Delaware.

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(Please put a check mark in the box next to the plan you have selected.)

If you are an undergraduate student or a non-funded graduate student, use this chart to determine your costs*.

September 1, 2008 to September 1, 2009				January 1, 2009 to September 1, 2009			
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>			<u>Blue Plan</u>	<u>Blue and Gold Plan</u>
Student Only:	<input type="checkbox"/>	\$1,623	<input type="checkbox"/> \$1,973	Student Only:	<input type="checkbox"/>	\$1,081	<input type="checkbox"/> \$1,314
Student & 1 Dependent:	<input type="checkbox"/>	\$4,153	<input type="checkbox"/> \$5,493	Student & 1 Dependent:	<input type="checkbox"/>	\$2,767	<input type="checkbox"/> \$3,661
Student & 2 or more				Student & 2 or more			
Dependents	<input type="checkbox"/>	\$6,090	<input type="checkbox"/> \$8,123	Dependents	<input type="checkbox"/>	\$4,059	<input type="checkbox"/> \$5,414
February 1, 2009 to September 1, 2009				June 1, 2009 to September 1, 2009			
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>			<u>Blue Plan</u>	<u>Blue and Gold Plan</u>
Student Only:	<input type="checkbox"/>	\$946	<input type="checkbox"/> \$1,150	Student Only:	<input type="checkbox"/>	\$408	<input type="checkbox"/> \$495
Student & 1 Dependent:	<input type="checkbox"/>	\$2,422	<input type="checkbox"/> \$3,204	Student & 1 Dependent:	<input type="checkbox"/>	\$1,040	<input type="checkbox"/> \$1,375
Student & 2 or more				Student & 2 or more			
Dependents	<input type="checkbox"/>	\$3,552	<input type="checkbox"/> \$4,738	Dependents	<input type="checkbox"/>	\$1,525	<input type="checkbox"/> \$2,033

*These costs include an Administrative Fee.

If you are a funded graduate, use this chart to determine your costs.

September 1, 2008 to September 1, 2009				September 1, 2008 to February 1, 2009			
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>			<u>Blue Plan</u>	<u>Blue and Gold Plan</u>
Student Only:	<input type="checkbox"/>	\$240	<input type="checkbox"/> \$590	Student Only:	<input type="checkbox"/>	\$101	<input type="checkbox"/> \$246
Student & 1 Dependent:	<input type="checkbox"/>	\$2,770	<input type="checkbox"/> \$4,110	Student & 1 Dependent:	<input type="checkbox"/>	\$1,155	<input type="checkbox"/> \$1,713
Student & 2 or more				Student & 2 or more			
Dependents	<input type="checkbox"/>	\$4,707	<input type="checkbox"/> \$6,740	Dependents	<input type="checkbox"/>	\$1,962	<input type="checkbox"/> \$2,809
February 1, 2009 to September 1, 2009							
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>				
Student Only:	<input type="checkbox"/>	\$139	<input type="checkbox"/> \$344				
Student & 1 Dependent:	<input type="checkbox"/>	\$1,615	<input type="checkbox"/> \$2,397				
Student & 2 or more							
Dependents	<input type="checkbox"/>	\$2,745	<input type="checkbox"/> \$3,931				

We suggest that you make a copy of this application for your files.

For expedited enrollment and confirmation of coverage you can enroll and pay on-line at www.universityhealthplans.com instead of completing the paper application.

PLEASE SUBMIT APPLICATION PRIOR TO START DATE TO ASSURE FULL COVERAGE.

Please pay by check or money order if you are using the paper application. (Use on-line system for credit card payments)

Make your check or money order for the total applicable premium listed above to **Nationwide Life Insurance Company**

Return this form with the total applicable premium listed above to: **University Health Plans, One Batterymarch Park, Quincy, MA 02169-7454**

Should you have any questions please contact: **University Health Plans at (800) 437-6448**