The University of Northern Iowa

SHIP ENROLLMENT FORM 2019-2020

PLEASE PRINT:

__________________________________________
Student Name (Last, First, M.I)

Sex: □M □F Date of Birth_________________

__________________________________________
Student ID Number SSN

2351 Hudson Road, HPC 106
Cedar Falls, IA 50614-0156

(319) 273-7031

Insurance Plan: □ SHIP

Contract Information: □ Student

I have read and understand the Agreement and Certification language below.

__________________________________________
Student’s Signature

__________________________________________
Date

To be completed by Camp Adventure Staff ONLY

Enrollment Beginning Date:

□ 08/01/2019 □ 09/01/2019 □ 10/01/2019
□ 11/01/2019 □ 12/01/2019 □ 01/01/2020
□ 02/01/2020 □ 03/01/2020 □ 04/01/2020
□ 05/01/2020 □ 06/01/2020 □ 07/01/2020
□ 08/01/2020

Termination date ____________
This must be at the end of a month.

**This fee is subject to change based on the rate released by the University of Northern Iowa for the 2019-2020 school year.**

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 false statements or misrepresentations, or have failed to disclose or conceal any material fact, Wellmark Blue Cross and Blue Shield of Iowa will be entitled to declare the health care contracts applied for void and to refuse allowance of benefits to any person there under.

I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably related to the health care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.