ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

Mail this Enrollment Form to:
WPS Health Insurance
P.O. Box 8190 Madison, Wisconsin 53708-8190

INSTRUCTIONS: Please complete the entire application.
Please print using **black** ink.

1. Reason for Application

Please indicate if you are:

❑ Full-Time Student ❑ International Student ❑ Other – Accelerated Programs

❑ Applying for Family Coverage

❑ Adding a Dependent: Name: _____ Effective Date: _____

❑ Addition Due To: ❑ Marriage – Date: _____ ❑ Birth – Date: _____

❑ Addition Due To: ❑ Adoption – Date: _____ ❑ Other – Date: _____

2. Information About You (Applicant)

Student Name: _____
Last First

Social Security No: _____ Student ID: _____

Gender: ❑ Male ❑ Female Date of Birth: _____ Expected Day of Graduation: _____
Month Year

Permanent Address: _____
Number & Street City State Zip County

Mailing Address: _____
Number & Street City State Zip County

Telephone Number: _____ E-Mail Address: _____

Name of School You Are Attending: _____

3. Information About Your Family (If enrolling dependents, please complete this section)

Last Name	First Name	MI	Gender	Birth Date	Relationship to Applicant

4. Notice to Student/Signature

Coverage will be effective the date the correct premium is received by the Insurer, or a representative of the Insurer, or the effective date of the coverage period, whichever is later. By signing, the student acknowledges the following: (1) he/she has carefully read the brochure and elects to enroll as indicated on this enrollment form; (2) rates are not pro-rated other than as listed on this enrollment form; (3) he/she meets the eligibility requirements for this coverage as described in the brochure; and (4) if it is later determined that the student is not eligible, the premium will be refunded and coverage will not be in effect. **Premium will not be not be refunded except for ineligibility or entrance into the armed forces.**

I understand the policy is not renewable. I further understand and agree that the Insurer, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorneys' fees) I, my spouse or any dependent(s) suffer as a result of any improper advice, action, or omission on the part of any health care provider. I understand that the Insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the Insurer may rescind and void any coverage if it determines that a covered student or a covered student's spouse or named dependent are either listed on the SDN list or associated with an entity listed on the SDN list.

Student's Signature: _____ Date: _____

5. Coverage Election – Please Check All Appropriate Boxes

Effective/Expiration Periods:
- ❑ Annual: 08-01-2015 to 07-31-2016 (12 months)
- ❑ Fall: 08-01-2015 to 12-31-2015 (5 months)
- ❑ Spring/Summer: 01-01-2016 to 07-31-2016 (7 months)
- ❑ Monthly Coverage (applies only to **international** students)

Plan Choice: ❑ High Deductible Plan ❑ $0 Deductible Plan ❑ International Student Plan

To calculate your premium, multiply the rate stated in the rate brochure times the number of months purchased.

Number of months purchased: _____

Total premium due: _____

6. Information About Other Medical Coverage

Will you or any family member(s) continue or maintain any other health coverage in addition to the insurance being applied for today? ❑ No ❑ Yes If yes, list all coverage in the last 270 days:

Policyholder Information	Name, Address & Phone Number of Insurance Company/Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: ❑ Student ❑Spouse Birth Date: _____			❑ Single ❑Family	❑ Medical ❑ Dental		
Name: ❑ Student ❑Spouse Birth Date: _____			❑ Single ❑Family	❑ Medical ❑ Dental		

You have a right to request a certificate of creditable coverage from your prior plan. If necessary, we will assist you in obtaining a certificate from the prior plan. If you received a certificate of coverage from your prior plan, please attach a copy to this enrollment form.

7. Payment Information

❑ Charge Full Amount: _____

❑ Visa ❑ Master Card

Expiration Date: _____

Authorized Signature: _____ Date: _____

Name as it Appears on Credit Card: _____

Address Associated with Credit Card: _____

OR

❑ Paid by Check Number: _____ Amount Paid: _____

Make check or money order payable to WPS or refer to the charge card authorization above to charge your premium to Visa or Master Card.

Mail this enrollment form with premium payment to: **WPS Health Insurance ♦ P.O. Box 8190 ♦ Madison, WI 53708-8190**

Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.**