

# ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



Mail this enrollment form to:  
WPS Health Insurance | P.O. Box 8190 | Madison, WI 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 Number: \_\_\_\_\_ Student ID: \_\_\_\_\_  
 Gender:  Male     Female   
 Date of Birth: \_\_\_\_\_   
 Expected Date of Graduation: \_\_\_\_\_  
Month Year  
 Permanent Address: \_\_\_\_\_  
Number & Street City State ZIP County  
 Mailing Address: \_\_\_\_\_  
Number & Street City State ZIP County  
 Telephone Number: \_\_\_\_\_ Email 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

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) he/she meets the eligibility requirements for this coverage as described in the brochure; and (3) 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 refunded except for ineligibility or entrance into the armed forces.**

I understand the policy is renewable as long as I remain an eligible policyholder. 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 attorney's 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 the covered policyholder, covered policyholder'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

Please indicate your requested effective date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please indicate your requested termination date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

The policy effective and termination dates will be determined by the insurer, subject to any applicable law or policy provisions.

Plan Choice:       \$6,350 High-Deductible Plan       \$3,000 Deductible Plan       International Student Plan

## 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, please complete the following chart.

Policyholder Information	Name, Address, and Phone Number of Insurance Company/Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: <input type="checkbox"/> Student <input type="checkbox"/> Spouse Date of Birth: _____			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Name: <input type="checkbox"/> Student <input type="checkbox"/> Spouse Date of Birth: _____			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		

## 7. Payment Information

Credit/Debit Card

Email: \_\_\_\_\_

For security reasons, a valid email address is required for online payment with a credit or debit card. A WPS representative will contact you via email regarding how to make a payment online. By providing your email address, you are authorizing a WPS representative to contact you for purposes of online payment.

**OR**

Paid by Check Number: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Make check or money order payable to WPS. Mail this enrollment form and premium payment to:

**WPS Health Insurance**  
**P.O. Box 8190**  
**Madison, WI 53708-8190**

Your canceled 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.**

**Internal use only:**

Group Number: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_ Notes: \_\_\_\_\_