

**MGH INSTITUTE OF HEALTH PROFESSIONS**  
**Nationwide Life Insurance Company - Student Medical Plan**  
**2010-11 Qualifying Event Enrollment Form**

**STUDENT INFORMATION:**

Student Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender: \_\_\_\_ Email Address: \_\_\_\_\_ Telephone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Mailing Address: (Street Address) \_\_\_\_\_  
 (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

**DEPENDENT INFORMATION (if applicable):**

Spouse's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_  
 Child's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_  
 Child's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_  
 Child's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_

**ENROLLMENT INSTRUCTIONS:** Refer to the table below for eligible enrollment reasons, required documentation and the deadlines. The effective date of your new MGHIHP plan will be retroactively effective to the date noted in the table. **If your "reason for late enrollment" is not listed below or if the deadline has passed, you are not eligible to enroll at this time and must wait until the next policy year which will start 5/1/11.**

Person To Be Enrolled	Reason for Late Enrollment	A copy of the following documentation is required.	UHP must receive the completed enrollment form <u>and</u> appropriate documentation within:	The effective date of the new MGHIHP coverage will be:
Student	Termination of Prior Coverage	Insurance document showing the date of termination	31 days following prior coverage termination.	the date of prior coverage termination.
Spouse	Termination of Prior Coverage	Insurance document showing the date of termination	31 days following prior coverage termination.	the date of prior coverage termination.
Spouse	Entry into U.S.	Identification page of Passport and page with U.S. entry date stamp	31 days following date of entry into the U.S.	the date of entry into the U.S.
Spouse	Marriage to Student	Marriage certificate	31 days following date of marriage.	the date of marriage.
Child(ren)	Termination of Prior Coverage	Insurance document showing the date of termination	31 days following prior coverage termination.	the date of prior coverage termination.
Child(ren)	Birth	Birth certificate, if available	31 days following date of birth.	the date of birth.
Child(ren)	Adoption	Official adoption papers showing date of adoption	31 days following adoption.	the date of adoption.

**PREMIUM INFORMATION:** Upon receipt of this enrollment form and all required documentation, University Health Plans will contact MGHIHP to have the insurance premium amount added to the student account. To find out what the amount for your enrollment would be, please contact University Health Plans.

**MAILING INSTRUCTIONS:** Mail the completed enrollment form and a copy of the required supporting documentation (refer to table above) to: University Health Plans, One Batterymarch Park, Quincy, MA 02169. You will receive an insurance card (or updated insurance cards, if you're adding dependents to your existing plan) approximately 10 business days after both the required form and supporting documentation is received by University Health Plans.

**ENROLLMENT REQUIREMENTS CHECKLIST:**

- Contact University Health Plans for rate information..
- Complete this form.
- Include the required documentation (see above table). ALL enrollments require something in addition to this form. Your enrollment request cannot be processed without it.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*If you have any questions, please contact University Health Plans at 800-437-6448 or [info@univhealthplans.com](mailto:info@univhealthplans.com).\*\*\***