UMASS-WORCESTER 2010-2011 STUDENT HEALTH INSURANCE PLAN
DEPENDENT ENROLLMENT FORM

(PLEASE PRINT)

Student Name_____
Last First MI

Mailing Address_____
Street or PO Box City State Zip

Student ID #_____Date of Birth_____Phone#_____Gender:_____

If you are enrolling Dependents, list Dependents to be insured below.
Dependent coverage is available ONLY if the student is also insured under the Plan.

	Last Name	First Name	Date of Birth	Gender	PCP Name	PCP#
Spouse:						
Child:						
Child:						

QUARTERLY RATES	Fall	Winter	Spring	Summer
Dependent(s) Coverage of -- 1st Year GSBS Early Start (7/1/2010-8/31/2010)	$2,237 (7/1/10-11/30/10)	$1,343 (12/1/10-2/28/11)	$1,343 (3/1/11-5/31/11)	$1,343 (6/1/10-8/31/11)
Dependent(s) Coverage of -- 1st Year SOM/GSN MS/GEP (8/1/2010-8/31/2010)	$1,791 (8/1/10-11/30/10)	$1,343 (12/1/10-2/28/11)	$1,343 (3/1/11-5/31/11)	$1,343 (6/1/10-8/31/11)
Dependent(s) Coverage of -- 1st Year GSBS/GSN PhD, & -- all returning students (9/1/2010-8/31/2010)	$1,343.25 (9/1/10-11/30/10	$1,343.25 (12/1/10-2/28/11)	$1,343.25 (3/1/11-5/31/11)	$1,343.25 (6/1/10-8/31/11)

Dependent Enrollment Deadlines:

Fall Term Enrollment:	September 30, 2010
Winter Term Enrollment:	November 30, 2010
Spring Term Enrollment:	February 28, 2011
Summer Term Enrollment:	May 31, 2011

Payment Instructions: Please mail completed form and premium to: University Health Plans, One Batterymarch Park, Quincy, MA 02169-7456. ***Please note Credit Card payments are not accepted for quarterly payments. Payment should be made in the form of a Personal Check, US Bank Check or US Money Order payable to University Health Plans.***

When you join the University of Massachusetts Worcester Blue Choice New England Student Health Insurance Plan, the University requires students to select the Student Health Center (SHC) as the student's Primary Care Physician (PCP). When treated at the Student Health Center, per visit copays are waived. When referred by the SHC to a non-SHC provider, the student is responsible for a per visit copay. When a referral has not been granted by the SHC, the student will be responsible for deductibles and co-insurance. If you are purchasing coverage for your Dependents under this plan, they may choose other PCP's. Please note that the PCP selection for Dependents must be made at the time of enrollment.

NOTE: Annual coverage for **dependents** may be paid on a Quarterly Basis (Fall, Winter, Spring and Summer). A reminder notice will be issued by University Health Plans, Inc., prior to the next payment due date. However, it should be noted that in order to have continuous coverage, payment of the next quarterly premium must be received by the above deadlines. If the Quarterly Installment is received after the above payment deadline date, coverage will cease as of the last day of the previous term of coverage. Please note that timely payment of installments is the responsibility of the insured student. UMASS-Worcester, University Health Plans, Inc., or BCBS will not be held liable in the event of late payment and subsequent cancellation of coverage.

STUDENT'S SIGNATURE: _____DATE: _____

Please contact University Health Plans at info@univhealthplans.com or (800) 437-6448 if you have any questions about enrolling your dependents in the plan.