SUFFOLK UNIVERSITY

Blue Cross Blue Shield of MA - Student Medical Plan

2015-2016 Qualifying Event Enrollment Form

STUDENT INFORMATION:

Student Name: (Last)_____ (First)_____ (MI)____ Date of Birth: _____ / _____ / _____

Student ID#: _____ Gender: ___ Email Address: _____Telephone #: ____ - ____ - _____

Mailing Address: (Street Address)_____

(City)_____ (State)_____ (Zip Code)_____

Please check the following that applies to your student status: UG ____ GR____ Law_____

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: _____

ENROLLMENT INSTRUCTIONS: Refer to the table below for eligible enrollment reasons, required documentation and the deadlines. The effective date of your new Suffolk University insurance 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 Fall 2016.**

Person To Be Enrolled	Reason for Late Enrollment	A copy of the following documentation is required.	UHP must receive the completed enrollment form and appropriate documentation within:	The effective date of the new Suffolk coverage will be:
Student	Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	the date of prior coverage termination.
Spouse	Termination of Prior Coverage	Insurance document showing the date of termination	60 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	60 days following date of entry into the U.S.	the date of entry into the U.S.
Spouse	Marriage to Student	Marriage certificate	60 days following date of marriage.	the date of marriage.
Child(ren)	Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	the date of prior coverage termination.
Child(ren)	Birth	Birth certificate, if available	60 days following date of birth.	the date of birth.
Child(ren)	Adoption	Official adoption papers showing date of adoption	60 days following adoption.	the date of adoption.

PREMIUM INFORMATION: Please contact University Health Plans for information about premium that you may need to include with this form. ***Please note Credit Card payments are not accepted. Payment should be made in the form of a Personal Check, US Bank Check or US Money Order payable to 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) 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 rates.
- ☐ Include the required documentation (see above table). ALL enrollments require something in addition to this form. Your enrollment request cannot be processed without it.
- ☐ Include check/money order made payable to University Health Plans.
- ☐ Complete this form.

Student Signature: _____ Date: _____

*****If you have any questions, please contact University Health Plans at 800-437-6448 or info@univhealthplans.com*****