UNIVERSITY OF MASSACHUSETTS - LOWELL

Student Health Insurance Plan: **Dependent Qualifying Life Event Enrollment Form**

STUDENT INFORMATION

Student ID _____ Last Name _____ First Name _____ MI _____

Gender _____ Date of Birth ____ / ____ / _____ Email Address _____

Address _____

City _____ State _____ Zip Code _____

STUDENT INFORMATION

Spouse's Name (Last) _____ (First) _____ DOB: ___/___/___ Gender (M/F): ____

Child's Name (Last) _____ (First) _____ DOB: ___/___/___ Gender (M/F): ____

Child's Name (Last) _____ (First) _____ DOB: ___/___/___ Gender (M/F): ____

Child's Name (Last) _____ (First) _____ DOB: ___/___/___ Gender (M/F): ____

Enrollment Instructions: Refer to the table below for eligible enrollment reasons, required documentation and applicable deadlines. If your "Qualifying Event" is not listed below or the deadline has passed, you are not eligible to enroll at this time and must wait until the next policy period begins.

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:	UMASS Lowell SHIP Effective Date
Spouse	Involuntary Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	the date of prior coverage termination.
Spouse/ Children	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.
Children	Involuntary Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	the date of prior coverage termination.
Children	Birth	Birth certificate, if available	60 days following date of birth.	the date of birth.
Children	Adoption	Official adoption papers showing date of adoption	60 days following adoption.	the date of adoption.

Effective Date: The Student Health Insurance Plan will be made effective as of the first date you became or will become uninsured or the date you entered the US.

Benefits: Benefit information is available at www.universityhealthplans.com/UML

Payment/Delivery Instructions: Contact University Health plans for premium information at 1-800-437-6448. Make check or money order payable to **RSC Insurance Brokerage, Inc.** *In the memo section include: Name, Student ID and School Name.*

Mail: (1) the completed enrollment form, (2) a copy of the required supporting documentation and (3) check or money order to: **University Health Plans, 15 Pacella Park Drive, Randolph, MA 02368**. **All three items must be received within 60 days of the qualifying event.**

Notice to Student: By signing below and enrolling, the student acknowledges the following: 1) Student has carefully read the Summary of Benefits and elects to enroll as indicated on this enrollment form. 2) Student meets the eligibility requirements for this coverage. 3) If it is later determined that the student is not eligible, the premium will be refunded by the insurance company. 4) Other than eligibility, the premium is not refundable.

Student Signature: _____ **Date:** _____

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