

UMass Chan Medical School
Blue Cross Blue Shield - Student Medical Plan
2023-2024 Dependents 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) _____

Last Date of Prior Insurance Coverage of Dependent: _____

DEPENDENT INFORMATION: If you do not want your dependent(s) PCP to be defaulted to Umass Memorial Student Health Services (SHS), please provide your dependent(s) PCP # below.

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

ENROLLMENT INSTRUCTIONS: Refer to the table below for eligible enrollment reasons, required documentation and the deadlines. The effective date of your Blue Cross Blue Shield 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 2024.**

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 BCBS coverage will be:
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 RSC Insurance Brokerage, Inc.* In the memo section include: Student Name and School Name.

MAILING INSTRUCTIONS: Mail the completed enrollment form, a copy of the required supporting documentation (refer to table above), and payment to: University Health Plans, 15 Pacella Park Drive, Suite 130, Randolph, MA 02368. 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:

- ☐ Include the required documentation (see above table). ALL enrollments require something in addition to this form. Your enrollment request cannot be processed without it.
- ☐ Contact University Health Plans for rates.
- ☐ Include check/money order made payable to RSC Insurance Brokerage Inc.

Student Signature: _____ Date: _____

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