UNIVERSITY of NORTHERN COLORADO

ACE American Insurance Company
2011-2012 Health Insurance Plan
Dependent Enrollment Form

STUDENT HEALTH INSURANCE OFFICE
CASSIDY HALL – CAMPUS BOX 46
GREELEY, COLORADO 80639
(970) 351-1915 FAX: (970) 351-3234

Premium Amount

	Spouse	Child(ren)
Fall	❑ $2,804.00	❑ $2,221.00
Spring/Summer	❑ $2,804.00	❑ $2,221.00
Summer	❑ $1,927.00	❑ $1,527.00

The cost includes a $72 administrative fee retained by the University.

Student Name:______________________ Bear#:______________

Date of Birth:______________ Gender: _____ Male _____ Female SSN#: ______________

Address:____
Street City State Zip

Telephone Number: (________)____________ Email Address:______________________

Spouse's Name: ______________________ ____________ ____________
Date of Birth Social Security #

1) ______________________ ____________ ____________ M / F
Child's Name Date of Birth Social Security # Gender

2) ______________________ ____________ ____________ M / F
Child's Name Date of Birth Social Security # Gender

3) ______________________ ____________ ____________ M / F
Child's Name Date of Birth Social Security # Gender

4) ______________________ ____________ ____________ M / F
Child's Name Date of Birth Social Security # Gender

Eligibility Requirement: Eligible students who enroll may enroll their Dependents. Dependent enrollment must take place at the initial time of student enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children. Dependent coverage is available only if the student is also insured. Dependent coverage cannot exceed the coverage of the Insured and expires concurrently with that of the Student. The cost of the insurance is non-refundable except a pro-rata refund of the cost will be made, if a dependent enters the United States armed forces while coverage is in effect.

CONDITIONS OF THIS ENROLLMENT:

1) Enrollment is open through the 10th class day of the semester.
2) Enrollment in the plan after the open enrollment period will require a change in insurance status.
3) I understand the insurance coverage will be in effect beginning ______________ and ending ______________
If I wish coverage beyond this time, I must contact the Student Health Insurance.

I understand that the Company maintains its right to investigate student status and attendance records to verify that the Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is refund of premium.

I understand my information is protected by privacy laws and will be released only in accordance with these laws. My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me the terms and conditions stated therein.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

______________________________ ______________
Signature of Student Date

For Office Use Only: Comments: ______________________________

Date Entered:______________ Flag Changed:______________
Entered By:____________ Eligibility:__________ Update: __________
E-Mail Sent to Student:______________ Letter: __________
Benefits Book:________ Medicat:________ Scanned:________ # of hours:________