UNIVERSITY of NORTHERN COLORADO

UniCare Life & Health Insurance Company
2009-2010 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	❑ $2,543.00	❑ $2,012.00
Spring/Summer	❑ $2,543.00	❑ $2,012.00
Summer	❑ $1,758.00	❑ $1,394.00

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 premium is non-refundable.

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.

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.

_____ _____
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:_____