

Received _____
Processed _____
Verified _____

2011-2012
University of Colorado
Anschutz Medical Campus
Student Accident and Sickness Health Plan
Dependent Enrollment Form

Office Use Only
Date Received _____
Received By _____ initials

If you are a dependent of a student enrolled on the Student Insurance Plan (Policy CHH8017822), you may enroll on this plan. The student must already be enrolled. For more information contact the Student Health/Insurance Office at 303-724-7674.

STUDENT ID # _____

PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name
First (Given) Name
Middle Initial

GENDER: Male Female
Check one

DATE OF BIRTH: _____ - _____ - _____
Month
Day
Year

PERMANENT ADDRESS: _____
House/Building Number and Street Name
Apt. or P.O. Box # or Rural Route

City
County
State
Zip Code

MAILING ADDRESS: _____
House/Building Number and Street Name
Apt. or P.O. Box # or Rural Route

City
County
State
Zip Code

TELEPHONE # _____ - _____ - _____

Complete information below for Dependents to be insured.
Dependent coverage is available only for Dependents of Students insured under the Student Insurance Plan.

SPOUSE: _____ - _____ - _____
Social Security Number
 Male Female
(Check one)
DATE OF BIRTH: _____ - _____ - _____
Month Day Year

First (Given) Name
M/I
Last (Family) Name

CHILD: _____ - _____ - _____
Social Security Number
 Male Female
(Check one)
DATE OF BIRTH: _____ - _____ - _____
Month Day Year

First (Given) Name
M/I
Last (Family) Name

CHILD: _____ - _____ - _____
Social Security Number
 Male Female
(Check one)
DATE OF BIRTH: _____ - _____ - _____
Month Day Year

First (Given) Name
M/I
Last (Family) Name

CHILD: _____ - _____ - _____
Social Security Number
 Male Female
(Check one)
DATE OF BIRTH: _____ - _____ - _____
Month Day Year

First (Given) Name
M/I
Last (Family) Name

NOTICE TO STUDENT: Coverage will be effective on the effective date of the coverage period if payment is received by the Company or a representative of the Company or the Student Health/Insurance Office by the Enrollment Deadline Date listed on the back of this form. In the event of a late enrollment, payment and this enrollment form must be received by the 30th day after loss of coverage under another group health plan and coverage will be effective the day of receipt. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

Student's Signature _____ Date _____

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I elect to purchase Accident and Sickness insurance coverage under the University of Colorado Anschutz Medical Campus Student Accident and Sickness Health Plan. Below are the choices I have made.

DEPENDENTS OF RETURNING STUDENTS					
EFFECTIVE AND TERMINATION DATES			ENROLLMENT DEADLINE DATE		
Annual.	09/01/11 through 08/31/12	. . . . .	09/01/11		
Fall	09/01/11 through 12/31/11	. . . . .	09/01/11		
Spring/Summer.	01/01/12 through 08/31/12	. . . . .	02/01/12		
Summer.	06/01/12 through 08/31/12	. . . . .	06/15/12		
DEPENDENT'S RATES					
		Annual	Fall	Spring/Summer	Summer
C. Spouse / Domestic Partner	Plan A	<input type="checkbox"/> \$4,870	<input type="checkbox"/> \$1,650	<input type="checkbox"/> \$3,260	<input type="checkbox"/> \$1,248
	Plan B	<input type="checkbox"/> \$3,780	<input type="checkbox"/> \$1,287	<input type="checkbox"/> \$2,533	<input type="checkbox"/> \$975
D. Each Child	Plan A	<input type="checkbox"/> \$3,646	<input type="checkbox"/> \$1,242	<input type="checkbox"/> \$2,444	<input type="checkbox"/> \$942
	Plan B	<input type="checkbox"/> \$2,832	<input type="checkbox"/> \$971	<input type="checkbox"/> \$1,901	<input type="checkbox"/> \$738

DEPENDENTS OF NEW STUDENTS/EARLY ARRIVALS					
EFFECTIVE AND TERMINATION DATES			ENROLLMENT DEADLINE DATE		
Annual.	08/08/11 through 08/31/12	. . . . .	09/01/11		
Fall	08/08/11 through 12/31/11	. . . . .	09/01/11		
Spring/Summer.	01/01/12 through 08/31/12	. . . . .	02/01/12		
Summer.	06/01/12 through 08/31/12	. . . . .	06/15/12		
DEPENDENT'S RATES					
		Annual	Fall	Spring/Summer	Summer
C. Spouse / Domestic Partner	Plan A	<input type="checkbox"/> \$4,870	<input type="checkbox"/> \$1,650	<input type="checkbox"/> \$3,260	<input type="checkbox"/> \$1,248
	Plan B	<input type="checkbox"/> \$3,780	<input type="checkbox"/> \$1,287	<input type="checkbox"/> \$2,533	<input type="checkbox"/> \$975
D. Each Child	Plan A	<input type="checkbox"/> \$3,646	<input type="checkbox"/> \$1,242	<input type="checkbox"/> \$2,444	<input type="checkbox"/> \$942
	Plan B	<input type="checkbox"/> \$2,832	<input type="checkbox"/> \$971	<input type="checkbox"/> \$1,901	<input type="checkbox"/> \$738

I specifically consent to the release of any information which may be protected under the Family Educational and Privacy Rights Act, including without limitation, records of enrollments, attendance or payment of tuition related to my attendance at any educational institution to the blanket policyholder, Ameriben/IEC Group, National Union Fire Insurance Company of Pittsburgh, Pa. or their legal representatives or attorneys-in-fact.

Payment Instructions: Make check or money order payable to "ECI" in US dollars or refer to the Charge Card Authorization below to charge your premium to Visa, MasterCard, Discover or American Express. Bring this enrollment form along with your payment to the Student Insurance Office, located in Education II North, Room 3208. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION			
Charge will read "ECI (Student Insurance)" on Statement.			
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMERICAN EXPRESS	Expiration Date _____	Month _____ Year _____
Credit Card # _____			
This Authorization allows ECI to charge my Credit Card for the charged premium.			
AUTHORIZED SIGNATURE _____		DATE _____	
OR PAID BY CHECK # _____		AMOUNT PAID \$ _____	