

Return to: UHS Insurance Advisor
 University Health Service
 Box 617, 250 Crittenden Blvd.
 Rochester, NY 14642
 FAX: 585-276-0149

**Aetna University Quality Care Plan
 FAMILY ENROLLMENT FORM**

For Office Use Only
 Start Date: _____
 Effective Date: _____

Full-time students with dependent children are eligible to enroll in this insurance plan. Students must enroll during specific open enrollment periods or when a qualifying event occurs. The UHS Health Insurance Options Form must also be completed and returned to the UHS Insurance Advisor. (See address in upper left corner of this form.)

① PERSONS COVERED

Self, Spouse, & Child(ren)
 Self & Child(ren)

List all members to be covered in Box 4.

② STUDENT/SUBSCRIBER INFORMATION

Social Security Number: _____ Sex: Male Female

Last Name: _____ First Name: _____

Local or Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Birthdate: ____/____/____
Area Code Month Day Year

③ PHYSICIAN INFORMATION – FOR THE STUDENT/SUBSCRIBER

Assign a UHS primary care physician for me.
 Last Name: _____ First Name: _____ Provider #: _____ Current Patient: Y N

I want to designate a physician for myself. (The physician must be in the Aetna Network. Check docfind on www.aetna.com for physicians in the Aetna Network of physicians in the Rochester area.)

Primary Care Physician Last Name: _____ First Name: _____ Current Patient: Y N
 Aetna Provider #: _____

④ PHYSICIAN INFORMATION -- FOR FAMILY MEMBERS

Assign a UHS physician for my spouse and children over age 16. (We will fill in the names of UHS physicians below.)

Member Name	Social Security Number	Sex	Birthdate (mm/dd/yy)	Primary Care Physician (Last Name, First Name)
Spouse* Information: <small>The University Health Service will assign a primary care physician for your spouse.</small>				
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
Child(ren) Information: <small>If more children, please attach separate sheet. University Health Service will assign a primary care physician for your child(ren) over the age of 16. Please select a pediatrician for child(ren) age 16 or under.</small>				
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	Y <input type="checkbox"/> N <input type="checkbox"/>
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	Y <input type="checkbox"/> N <input type="checkbox"/>

* Domestic partners must meet specific criteria to be eligible. If enrolling a domestic partner, check the UHS web site (www.rochester.edu/uhs) for information about criteria or contact the UHS Insurance Advisor at lstrang@uhs.rochester.edu or (585) 275-2637.

⑤ OTHER INSURANCE COVERAGE – Please complete if you intend to keep additional medical coverage in addition to the University Quality Care Plan.

Insurance Company _____ Policy ID # _____
 Policyholder/Subscriber Name _____ Effective Date of Coverage ____/____/____
 Dependents Covered _____

⑥ RELEASE – You must sign and date this form to be eligible for Insurance.

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and each of my family members who is covered under the Plan is bound by the terms and conditions of the Plan applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information to the Plan's third party administrator. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accepts coverage under the terms of the Plan applicable to my coverage (who may include, for example, my spouse, my domestic partner, and my eligible family dependents).
- I hereby accept responsibility for my share, if any, of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage cancelled upon one month's written notice, if I have knowingly included false information.
- I understand that I have elected a managed care produce and that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.

Student Signature _____ Date ____/____/____

For Office Use Only UHS Initials/Date: _____