University of Rochester, University Health Service

Eastman Dental Center

Health Insurance Options Form – 7/1/08-6/30/09

FOR OFFICE USE ONLY:

Insurance Effective Date: _____

YOUR PERSONAL INFORMATION *(Please print.)*

Gender ☐ M ☐ F

Marital Status ☐ Single ☐ Married

Social Security #: |___|___|___| - |___|___| - |___|___|___|___|

Last Name: _____ First Name, Middle Initial: _____

Local Rochester Address: _____
Street or Box Number City State Zip Code

Home Phone Number: (_____) _____ Work Phone #: (_____) _____

E-mail Address: _____ Date of Birth: |___|___| \ |___|___| \ |___|___|___|___|
Month Day Year

University Department: _____ Appointment Dates: From _____ to _____

SPOUSE'S INFORMATION Marriage Date: _____ (MM/DD/YYYY) Social Security #: _____

Name: _____ Date of Birth: _____ (MM/DD/YYYY) Gender ☐ M ☐ F

INFORMATION ABOUT DEPENDENT(S)

Name: _____ Date of Birth: _____ (MM/DD/YYYY) ☐ M ☐ F

Name: _____ Date of Birth: _____ (MM/DD/YYYY) ☐ M ☐ F

ENROLLMENT OPTIONS *(Check the appropriate box. Sign and date on the appropriate line.)*

☐ **Blue Cross Blue Shield for individual student** plus the mandatory health fee. **$1,728/year**

I understand that I need to call UHS before going to an emergency department or seeing a specialist for care and that my visit may not be covered if I do not have a referral prior to my visit.

X _____
Signature Date

☐ **Blue Cross Blue Shield for student and spouse** plus the mandatory health fee for both. **$3,456/year**

My spouse and I understand that we both need to call UHS before going to an emergency department or seeing a specialist for care and that our visits may not be covered if we do not have a referral prior to our visits.

X _____
Signature Date

☐ **University High Deductible Plan family insurance** for myself, my spouse, & my child(ren) plus coverage provided by the mandatory health fee for you. **$1,040.79/month** *(Will increase 1/09)*

If you are selecting this option, you must also complete the University High Deductible Plan Enrollment Form.

X _____
Signature Date

☐ **Mandatory Health Fee only** (UHS office visits only). **$600/year**
You must have your own health insurance in addition to the mandatory health fee.

I understand that I will be paying the mandatory health fee, which covers office visits to the University Health Service. I understand that I must have health insurance and that I am responsible for charges not covered by insurance plan.

My insurance coverage is: **This section must be completed if you choose this option.**

Name of Insurance Company: _____ Phone # of Company: _____

Address: _____

Contract/policy #: _____ Name of Policy Holder: _____

X _____ X _____
Signature of Policy Holder Date Signature of Student Date

UHS INSURANCE ADVISOR: (585) 275-2637 / Fax: (585) 461-4637 / E-mail: insurance@uhs.rochester.edu
Mailing Address: University Health Service, Box 270472, Rochester, NY 14627