

University High Deductible Plan

With Aetna as your Third-Party Administrator

FOR OFFICE USE ONLY:

Start Date: _____

Effective Date: _____

Enrollment Form

Full-time students and post doctoral fellows (on a training grant) who have at least one dependent child are eligible to enroll in the University High Deductible Health Insurance. Enrollment is during the student's first time of eligibility (i.e., during the first month of full-time matriculation) or when a qualifying event occurs. To enroll, students must complete: (1) Enrollment Form. (address at bottom of this form) and (2) Health Insurance Selection Process. The link to the online selection process is on the UHS web site at www.rochester.edu/uhs. (See pink box in left column of the UHS home page.)

YOUR PERSONAL INFORMATION

First Name, Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ Gender: M F
(MM/DD/YYYY)

Address: _____
Street or Box Number City State Zip Code

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

DEPENDENT INFORMATION – List your dependents who will be covered by this plan.

MEMBER NAME	SOCIAL SECURITY NUMBER	GENDER	BIRTHDATE
SPOUSE * INFORMATION			
			mm/dd/yy
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____
CHILD(REN) INFORMATION (If more children, attach separate sheet.)			
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____
Last Name, First Name		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____

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

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 are covered under the Plan are 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 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.

Signature

Date

RETURN FORM TO:

UHS Insurance Advisor
University Health Service Building, Room 204 (on the River Campus)
P.O. Box 270617, Rochester, New York 14627
PHONE: 585-275-2637 FAX: 585-756-0263 E-MAIL: insurance@uhs.rochester.edu