# University of Rochester - Student Health Insurance Plan (SHIP)
# Special Program Insurance Application for 2023 - 2024 Student Health Insurance Enrollment Form
## *In order to enroll you must complete steps 1 through 4!*

**Please return this form to UHS Insurance Advisor at insurance@uhs.rochester.edu or by fax (585-756-0263) or in person (Room 404, UHS Building).**

This form contains important information concerning your health care coverage while you are participating in a special semester or academic year program. If you are participating in one of the special programs listed below (See #2: Check the Appropriate Program), you are eligible to enroll/continue enrollment in the University of Rochester Student Health Insurance Plan.

Please complete this form and return it to the UHS Insurance Advisor who will assist you with the enrollment process. You should complete this form *before* the start of the semester or the year in which you will begin the program. You will be billed for the mandatory health fee and Aetna Student Health insurance on your tuition billing statement.

**IF YOU HAVE QUESTIONS:** Write to the UHS Insurance Advisor at insurance@uhs.rochester.edu. Information about the University of Rochester Student Health Insurance Plan is available on the UHS web site (www.rochester.edu/uhs). Click on "Health Insurance for full-time students" in the Quick Links box. You can also call University Health Service at 585-275-2637.

1. ***Complete all Student information. Incomplete information will delay processing!***

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Student Name _____ _____ _____
Legal Last Name | Legal First Name | MI

Student ID # _____ Email address _____

Mailing Address _____ _____
This address will be used for all University of Rochester Student Health Insurance Plan communications | Apt.#

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____ Sex Male ☐ Female ☐ Other ☐ Gender X ☐
mm/dd/yy

2. **CHECK THE APPROPRIATE PROGRAM:**
   1. _____ Study Abroad (Please return form by August 15 if studying abroad in the fall or January 15 if studying abroad in the spring semester)
   2. _____ Internship/Co-Op/Visiting
   3. _____ Final semester part-time (less than 12 credit hour)]
   4. _____ Part-time for one semester only (will be full-time in the following semester)
   5. _____ In Absentia
   6. _____ Degree completion (August only)
   7. _____ Other (specify)_____

3. **SPECIFY THE SEMESTER(S) FOR WHICH COVERAGE IS DESIRED:**

**Form ID: UR823SPECIALENRO**

| Please Select One | Coverage | Date Range of Coverage | Deadline | Amount to be Bursar Billed |
|---|---|---|---|---|
| | **Annual Rate** | **08/01/23 - 07/31/24** | **9/15/23** | **$3,612** |
| | **Spring Rate** | **01/01/24 - 07/31/24** | **1/31/24** | **$2,107** |

4. **Notice to Student (Signature required)** I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse/partner and children can be made void. I understand that if it is later determined that I am not eligible (see the Student Health Insurance Plan Certificate of Coverage for eligibility guidelines), the premium will be refunded. You will also receive a Certificate of Coverage that outlines the benefits of the plan. You may return this Certificate to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Certificate. We will refund any Premium paid including any Certificate fees or other charges.

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the date of that policy period.** If it is received after the deadline, the University may reach out to Aetna Student Health

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**Signature**: _____ **Date**: _____

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