

University of Rochester - Student Health Insurance Plan (SHIP)

(for students eligible for voluntary enrollment)

Student Application for 2023 - 2024 Student Health Insurance Enrollment Form

In order to enroll you must complete steps 1 through 3!

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).

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

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Student Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Legal Last Name	Legal First Name	MI
Student ID #	<input type="text"/>	Email address	<input type="text"/>
Mailing Address	<input type="text"/>		<input type="text"/>
	This address will be used for all University of Rochester Student Health Insurance Plan communications		Apt.#
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Phone Number	<input type="text"/>	Date of Birth	<input type="text"/>
		mm/dd/yy	
		Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Gender X <input type="checkbox"/>

2. Select Enrollment Plan

Form ID: UR823ENRO – Coverage rates for 1 Student

Please Select One	Months of 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
	11 Months	09/01/23 - 07/31/24	9/30/23	\$3,311
	10 Months	10/01/23 - 07/31/24	10/31/23	\$3,010
	9 Months	11/01/23 - 07/31/24	11/30/23	\$2,709
	8 Months	12/01/23 - 07/31/24	12/31/23	\$2,408
	7 Months	01/01/24 - 07/31/24	1/31/24	\$2,107
	6 Months	02/01/24 - 07/31/24	2/28/24	\$1,806
	5 Months	03/01/24 - 07/31/24	3/31/24	\$1,505
	4 Months	04/01/24 - 07/31/24	4/30/24	\$1,204
	3 Months	05/01/24 - 07/31/24	5/31/24	\$903
	2 Months	06/01/24 - 07/31/24	6/30/24	\$602
	1 Months	07/01/24 - 07/31/24	7/31/24	\$301

3. 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: _____

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)