

University of Delaware Student Accident & Sickness Insurance Application

A. PERSONAL INFORMATION (Please Print)

LAST NAME, FIRST NAME, MIDDLE INITIAL _____ SOCIAL SECURITY NUMBER _____ SEX - Circle One _____ DATE OF BIRTH _____ STATUS _____
M / F _____ Post Doc _____
HOME ADDRESS - Street, City, State, Zip Code _____
E-mail address: _____

B. OTHER COVERAGE INFORMATION

Are you or any family members covered by other health insurance? (circle one) YES / NO If Yes, please complete the following:
Name of Insurance Company _____ Address of where claims are submitted to: _____
Name of Policyholder _____ Policy Identification Number _____ Effective Date of Policy _____
Is this an Employer Policy? Yes / No If Yes, Employer Name: _____
Who is covered? Circle all that are applicable:
Student / Spouse / Dependent Child(ren)

C. INDIVIDUALS TO BE COVERED

Eligible Dependents Definition: Dependents must be born to you or your spouse or legally adopted, under age of 19 and unmarried, and dependent on you for support as defined by the Internal Revenue Service (IRS)

Spouse's First Name	M.I.	Spouse's Last Name - if different	Date of Birth	Sex
_____	_____	_____	_____	_____
Dependent's First Name	M.I.	Dependent's Last Name - if different	Date of Birth	Sex
_____	_____	_____	_____	_____
Dependent's First Name	M.I.	Dependent's Last Name - if different	Date of Birth	Sex
_____	_____	_____	_____	_____

D. TERMS OF AGREEMENT

- * My application is subject to acceptance by Nationwide Life Insurance Company.
- * I authorize any physician, hospital and or any other health care provider to release information available to them as to diagnosis, treatment or any other health care services they render to me or my covered dependents to the Nationwide Life Insurance Company or their legal representative.
- * I also authorize Nationwide Life Insurance Company to release appropriate diagnostic and medical information to other persons in connection with a claim for coordination of benefits or other purposes related to this contract.
- * I am being offered Plan Blue and Plan Blue and Gold health insurance from the Nationwide Life Insurance Company and have chosen the plan appropriate for my needs.
- * I understand that if my application is accepted my coverage will end on the end date which I selected and I will be responsible for any continued coverage after the end date.
- * I certify that I am an admitted University of Delaware student as of the date of this application.

SIGNATURE OF APPLICANT _____

(BACK OF APPLICATION MUST BE COMPLETED)

DATE OF APPLICATION - Month, Day, Year _____

X _____

This application is for Post Docs only.

Return completed application by coverage start date to:

**University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454**

University of Delaware Student Accident & Sickness Insurance Application for Coverage for U.S. Citizens and Permanent Resident Immigrants

(Please put a check mark in the box next to the plan you have selected.)

September 1, 2008 to September 1, 2009				September 1, 2008 to February 1, 2009			
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>			<u>Blue Plan</u>	<u>Blue and Gold Plan</u>
Student Only:	<input type="checkbox"/>	\$480	<input type="checkbox"/> \$830	Student Only:	<input type="checkbox"/>	\$201	<input type="checkbox"/> \$346
Student & 1 Dependent:	<input type="checkbox"/>	\$3,010	<input type="checkbox"/> \$4,350	Student & 1 Dependent:	<input type="checkbox"/>	\$1,255	<input type="checkbox"/> \$1,813
Student & 2 or more				Student & 2 or more			
Dependents	<input type="checkbox"/>	\$4,947	<input type="checkbox"/> \$6,980	Dependents	<input type="checkbox"/>	\$2,062	<input type="checkbox"/> \$2,909
February 1, 2009 to September 1, 2009							
		<u>Blue Plan</u>	<u>Blue and Gold Plan</u>				
Student Only:	<input type="checkbox"/>	\$279	<input type="checkbox"/> \$484				
Student & 1 Dependent:	<input type="checkbox"/>	\$1,755	<input type="checkbox"/> \$2,537				
Student & 2 or more							
Dependents	<input type="checkbox"/>	\$2,885	<input type="checkbox"/> \$4,071				
*These costs include an Administrative Fee.							

We suggest that you make a copy of this application for your files.

For expedited enrollment and confirmation of coverage you can enroll and pay on-line at www.universityhealthplans.com instead of completing the paper application.

PLEASE SUBMIT APPLICATION PRIOR TO START DATE TO ASSURE FULL COVERAGE.

Please pay by check or money order if you are using the paper application. (Use on-line system for credit card payments)

Make your check or money order for the total applicable premium listed above to **Nationwide Life Insurance Company**

Return this form with the total applicable premium listed above to: **University Health Plans, One Batterymarch Park, Quincy, MA 02169-7454**

Should you have any questions please contact: **University Health Plans at (800) 437-6448**