

University of Delaware Student Accident & Sickness Insurance Application

APPLICATION FOR FOREIGN STUDENTS WHO WHICH TO UPGRADE OR ADD DEPENDENTS/SPOUSE

A. PERSONAL INFORMATION (Please Print)

<small>LAST NAME, FIRST NAME, MIDDLE INITIAL</small>	<small>SOCIAL SECURITY NUMBER</small>	<small>SEX - Circle One</small>	<small>DATE OF BIRTH</small>	<small>STATUS - Check One</small>
_____	_____	M / F	_____	<input type="checkbox"/> Non-Funded Graduate <input type="checkbox"/> Undergraduate Student <input type="checkbox"/> Funded Graduate ¹ <input type="checkbox"/> Post Doc
<small>HOME ADDRESS - Street, City, State, Zip Code</small>				

<small>E-mail address:</small>				

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:
<small>Name of Insurance Company</small>	<small>Address of where claims are submitted to:</small>		Is this an Employer Policy? Yes / No
_____	_____		If Yes, Employer Name:
<small>Name of Policyholder</small>	<small>Policy Identification Number</small>	<small>Effective Date of Policy</small>	<small>Who is covered? Circle all that are applicable:</small>
_____	_____	_____	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)

<small>Spouse's First Name</small>	<small>M.I.</small>	<small>Spouse's Last Name - if different</small>	<small>Date of Birth</small>	<small>Spouse's Social Security Number</small>
_____	_____	_____	_____	_____
<small>Dependent's First Name</small>	<small>M.I.</small>	<small>Dependent's Last Name - if different</small>	<small>Date of Birth</small>	<small>Dependent's Social Security Number</small>
_____	_____	_____	_____	_____
<small>Dependent's First Name</small>	<small>M.I.</small>	<small>Dependent's Last Name - if different</small>	<small>Date of Birth</small>	<small>Dependent's Social Security Number</small>
_____	_____	_____	_____	_____

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 foreign students holding F1 and J1 Visas who wish to upgrade to the Blue Gold Plan or who wish to add dependents or spouse to the plan.

Return completed application by coverage start date to:

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

¹ Graduate student receiving stipend and/or tuition from the University of Delaware.

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

This table is to be used only if you are an international student and want to add Blue Gold coverage or add dependent and/or spouse*.

September 1, 2003 to September 1, 2004			January 1, 2004 to September 1, 2004		
	<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"/> \$1,279	<input type="checkbox"/> \$174	Student Only:	<input type="checkbox"/> \$852	<input type="checkbox"/> \$116
One Dependent	<input type="checkbox"/> \$1,279	<input type="checkbox"/> \$1,884	One Dependent	<input type="checkbox"/> \$852	<input type="checkbox"/> \$1,256
Two or more dependents	<input type="checkbox"/> \$2,232	<input type="checkbox"/> \$3,169	Two or more dependents	<input type="checkbox"/> \$1,488	<input type="checkbox"/> \$2,112
February 1, 2004 to September 1, 2004			June 1, 2004 to September 1, 2004		
	<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"/> \$746	<input type="checkbox"/> \$101	Student Only:	<input type="checkbox"/> \$320	<input type="checkbox"/> \$44
One Dependent	<input type="checkbox"/> \$746	<input type="checkbox"/> \$1,099	One Dependent	<input type="checkbox"/> \$320	<input type="checkbox"/> \$471
Two or more dependents	<input type="checkbox"/> \$1,302	<input type="checkbox"/> \$1,848	Two or more dependents	<input type="checkbox"/> \$558	<input type="checkbox"/> \$793
September 1, 2003 to February 1, 2004					
	<u>Blue Plan</u>	<u>Blue and Gold Plan</u>			
Student Only:	<input type="checkbox"/> \$533	<input type="checkbox"/> \$73			
One Dependent	<input type="checkbox"/> \$533	<input type="checkbox"/> \$785			
Two or more dependents	<input type="checkbox"/> \$930	<input type="checkbox"/> \$1,321			
*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**