UW-MADISON STUDENT HEALTH INSURANCE PLAN APPLICATION

Student Health Insurance Plan
University Health Services
333 East Campus Mall, 7th Floor
Madison, WI 53715-1381

Phone: (608) 265-5232
Fax: (608) 265-5668
shipmail@uhs.wisc.edu
uhs.wisc.edu/ship

A. APPLICANT INFORMATION

University ID Number (10 digits)	First Name (Legal Name)	Middle Initial	Last Name

U.S. Mailing Address (your ID Card will be sent here)	Apt. Number	City	State	Zip Code

E-mail Address (use your wisc.edu address if available)	Contact Phone	Birth Date (month/day/year)	Gender ☐ Male ☐ Female

Plan Type:	Reason for Application:	Application Type:	Coverage Period:
☐ Domestic	☐ Student	☐ Single	☐ Annual (Aug 15 to Aug 14)
☐ International	☐ J-1 Scholar (new enrollee)	☐ Single + Child	☐ Fall (Aug 15 to Jan 14)
☐ J-1 Scholar (non-students)	☐ J-1 Scholar (renewing/extending)	☐ Single + Spouse/Partner	☐ Spring/Summer (Jan 15 to Aug 14)
	☐ Special Category (_____)	☐ Family	☐ Summer (class start date to Aug 14)
	☐ Involuntary Loss of Insurance Date of Loss: _____	***Signed affidavits are required for domestic partners***	☐ J-1 Scholar (non-students)
	☐ Add family member to plan		☐ Other

B. FAMILY INFORMATION: List all family members other than yourself to be covered. Print name as it should appear on the ID card.

First Name	Middle Initial	Last Name	Relationship	Gender	Birth Date (mm/dd/yy)
			☐ **Spouse** ☐ **Partner**	☐ M ☐ F	
			Child/Dependent	☐ M ☐ F	
			Child/Dependent	☐ M ☐ F	
			Child/Dependent	☐ M ☐ F	
			Child/Dependent	☐ M ☐ F	

C. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:

I hereby agree to the terms/conditions on the reverse side or second page of this form.

X _____ _____ / _____ / _____
Applicant Signature — Date Signed (month/day/year)

X _____ _____ / _____ / _____
Spouse/Partner Signature (If Applicable) — Date Signed (month/day/year)

MAILED ENROLLMENTS FOR REGISTERED STUDENTS ONLY:
Check Enclosed for $_____ (Payable to UW –Madison SHIP) ***Please remember to write your UW ID# on the check!***

THIS SECTION - FOR SHIP OFFICE USE ONLY

☐ CC Office:$ $	☐ CC Phone:$ $	☐ Check Office ☐ Mail:$	☐ Cash:$
☐ JRB #:	Total Premium: $	Late Fee: $	Total Payment: $	☐ Payment Only (School Year):

☐ **ANNUAL** (8/15 – 8/14)	☐ **FALL** (8/15 – 1/14)	☐ **SPRING/SUMMER** (1/15 – 8/14)

☐ **OTHER**	Billing Start:: /15/	Billing End: /14/	SHIP Starts:	SHIP Ends:
	Billing Start:: /15/	Billing End: /14/	SHIP Starts:	SHIP Ends:

J-1 Scholar-Later of DS2019 Start/Arrival:	J-1 Scholar DS-2019 End:

Received by: Date:	☐ Waiver Attached	☐ Remove Hold	Hold Removed by:

Enrollment entered in HPAD by:	Payment entered in HPAD by:

PROOF OF PAYMENT STAMP

CONSENT TO RELEASE INFORMATION

A Covered Person consents to the release of medical, legal, and/or enrollment information by any health care provider or by the University of Wisconsin-Madison Student Health Insurance Plan (SHIP) to the SHIP Claims Administrator, ***Consolidated Health Plans*** for himself/herself and for his/her Covered Dependent/s when he/she signs this form and when his/her SHIP Identification Card is used to receive health care services.

Each Covered Person authorizes and directs any person or institution that has examined or treated the Covered Person or his/her Covered Dependent/s to furnish to ***Consolidated Health Plans*** upon its request, any and all information and records or copies of records relating to the examination or treatment provided to the Covered Person or his/her Covered Dependent/s. ***Consolidated Health Plans*** agrees that such information and records will be considered confidential to the extent required by state and federal law. ***Consolidated Health Plans*** shall have the right to submit any and all records concerning health care services provided to the Covered Person or his/her Covered Dependent/s to appropriate medical review personnel.

AUTHORIZATION

I authorize, subject to State and Federal Law, any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition for myself or my Covered Dependent/s, to provide such information to ***Consolidated Health Plans***.

I understand the information obtained by use of this authorization will be used to determine eligibility for benefits. Any information obtained will not be released by ***Consolidated Health Plans*** to any person or organization except for reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully permitted, or as I may further authorize.

I understand that my medical records or those of my Covered Dependent/s may contain information regarding the diagnosis or treatment of a sexually transmitted infection (e.g. HIV/AIDS, gonorrhea, herpes, chlamydia, HPV), drug and/or alcohol abuse, mental illness or psychiatric treatment or counseling.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that ***Consolidated Health Plans*** may have the right to deny payment for any health care services on my behalf if I do not consent to release of medical information.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be valid as the original. I agree this authorization shall be valid for the period of time I am a Covered Person under this Plan or until any outstanding claims have been processed. I further understand that I may revoke this authorization at any time by notifying ***Consolidated Health Plans*** in writing at Consolidated Health Plans, 2077 Roosevelt Ave., Springfield, MA 01104. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

To the best of my knowledge, all statements and answers in this application are complete and true. If any information is determined to be false or inaccurate I understand coverage for myself and my Covered Dependent/s may be terminated at any time.

STATEMENT OF UNDERSTANDING

I understand and have carefully read the SHIP Summary and the Plan Document which are available on-line. I understand that rates are not pro-rated other than as specified in the Plan Document. I understand that I must meet the eligibility requirements for this coverage as described in the Plan Document; if it is later determined that I am not eligible, the premium will be refunded and I will not be entitled to coverage under the Plan. I understand that other than eligibility, the premium is not refundable unless otherwise detailed in the Plan Document.