ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

Mail this enrollment form to:
WPS Health Insurance | P.O. Box 8190 | Madison, Wisconsin 53708-8190

INSTRUCTIONS: Please complete the entire application. Please print using **black** ink.

1. Reason for Application

Please indicate if you are:

❑ Full-Time Student ❑ International Student ❑ Other – Accelerated Programs

❑ Applying for Family Coverage

❑ Adding a Dependent: Name: ______________________ Effective Date: ______________________

❑ Addition Due To: ❑ Marriage - Date ______________________ ❑ Birth - Date ______________________

❑ Addition Due To: ❑ Adoption - Date ______________________ ❑ Other/Date ______________________

2. Information About You (Applicant)

Student Name: ____
Last First

Social Security Number: ______________________ Student ID: ______________________

Gender: ❑ Male ❑ Female Date of Birth: ______________________ Expected Date of Graduation: ______________________
Month Year

Permanent Address: ____
Number & Street City State ZIP County

Mailing Address: ____
Number & Street City State ZIP County

Telephone Number: ______________________ Email Address: ______________________

Name of School You Are Attending: ____

3. Information About Your Family (If enrolling dependents, please complete this section)

Last Name	First Name	MI	Gender	Birth Date	Relationship to Applicant

4. Notice to Student/Signature

By signing, the student acknowledges the following: (1) he/she has carefully read the brochure and elects to enroll as indicated on this enrollment form; (2) he/she meets the eligibility requirements for this coverage as described in the brochure; and (3) if it is later determined that the student is not eligible, the premium will be refunded and coverage will not be in effect. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

I understand the policy is renewable as long as I remain an eligible policyholder. I further understand and agree that the Insurer, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) I, my spouse or any dependent(s) suffer as a result of any improper advice, action, or omission on the part of any health care provider. I understand that the Insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the Insurer may rescind and void any coverage if it determines the covered policyholder, covered policyholder's spouse, or named dependent are either listed on the SDN list or associated with an entity listed on the SDN list.

Student's Signature: ____ Date: ______________________

5. Coverage Election – Please Check All Appropriate Boxes

Please indicate your requested effective date: ________/________/_________

Please indicate your requested termination date: _______/_________/_________

The policy effective and termination dates will be determined by the insurer, subject to any applicable law or policy provisions.

Plan Choice: ❑ High-Deductible Plan ❑ $0 Deductible Plan ❑ International Student Plan

6. Information About Other Medical Coverage

Will you or any family member(s) continue or maintain any other health coverage in addition to the insurance being applied for today?
❑ No ❑ Yes If yes, please provide:

Policyholder Information	Name, Address, and Phone Number of Insurance Company/Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: ❑ Student ❑ Spouse Date of Birth: _________			❑ Family ❑ Single	❑ Medical ❑ Dental		
Name: ❑ Student ❑ Spouse Date of Birth: _________			❑ Family ❑ Single	❑ Medical ❑ Dental		

7. Payment Information

❑ Credit/Debit Card

Email: ____

For security reasons, a valid email address is required for online payment with a credit or debit card. A WPS representative will contact you via email regarding how to make a payment online. By providing your email address, you are authorizing a WPS representative to contact you for purposes of online payment.

OR

❑ Paid by Check Number: ______________________________ Amount Paid: ____

Make check or money order payable to WPS. Mail this enrollment form and premium payment to:
WPS Health Insurance
P.O. Box 8190
Madison, WI 53708-8190

Your canceled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.**

Internal use only:

Group Number:___________________ Subscriber Number:___________________ Notes:_________________________

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