UNIVERSITY OF
NORTHERN COLORADO

National Guardian Life Insurance Company
2016-2017 Health Insurance Plan
Fall Dependent Enrollment Form

STUDENT HEALTH INSURANCE OFFICE
CASSIDY HALL – CAMPUS BOX 46
GREELEY, COLORADO 80639
(970) 351-1915 FAX: (970) 351-3234

Premium Amount

	Spouse	Child(ren)
Fall	❑ $3,232.00*	❑ $2,542.00*

(*The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments.)

Student Name:_____ Bear#:_____

Date of Birth:_____ Gender: _____ Male _____ Female SSN#: _____

Address:_____
Street City State Zip

Telephone Number: (_____)_____ Email Address:_____

Spouse's Name: _____ _____ _____
Date of Birth Social Security #

1) _____ _____ _____ M / F
Child's Name Date of Birth Social Security # Gender

2) _____ _____ _____ M / F
Child's Name Date of Birth Social Security # Gender

3) _____ _____ _____ M / F
Child's Name Date of Birth Social Security # Gender

4) _____ _____ _____ M / F
Child's Name Date of Birth Social Security # Gender

Eligibility Requirement: Eligible students who enroll may enroll their Dependents. Dependent enrollment must take place at the time of student enrollment, with the exception of newborn or adopted children or a Qualifying Event. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student. The cost of the insurance is non-refundable except a pro-rata refund of the cost will be made, if a Dependent enters the United States armed forces while coverage is in effect.

CONDITIONS OF THIS ENROLLMENT:

1) Enrollment is open through the 10th class day of the semester.
2) Enrollment in the plan after the open enrollment period will require a change in insurance status.
3) I understand the insurance coverage will be in effect beginning _____ and ending _____
If I wish coverage beyond this time, I must contact the Student Health Insurance.

I understand that the Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium.

I understand my information is protected by privacy laws and will be released only in accordance with these laws. My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me the terms and conditions stated therein.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

_____ _____
Signature of Student Date

For Office Use Only: Comments: _____

_____

_____

Date Entered:_____ Flag Changed:_____
Entered By:_____ Eligibility:_____ Update: _____
E-Mail Sent to Student:_____ Letter: _____
Benefits Book:_____ Medicat:_____ Scanned:_____ # of hours:_____