SAINT LOUIS UNIVERSITY

SAINT LOUIS UNIVERSITY
UNIVERSITY HEALTH PLAN
Enrollment Application Form
Summer 2012

Student Health & Counseling Center
Marchetti Towers East
3518 Laclede Avenue
St. Louis, MO 63103
Fax: (314) 977-7165

INCOMPLETE INFORMATION WILL DELAY APPLICATION PROCESSING AND PRODUCTION OF MEMBER ID CARD(S)

COVERAGE OPTION	SINGLE	DOUBLE	FAMILY
Option #1: ☐ Summer Coverage (05/20/12 – 08/14/12) * ***Students graduating Spring 2012 are not eligible. See UHP website for Continuation Coverage options.***	$ 570	$1,140	$1,710

STUDENT CLASSIFICATION (Select one)

Undergraduate Student ☐ Graduate/Professional Student ☐ Graduate Assistant (Frost) ☐

Is Primary Member in the U.S. under an active **F-1, J-1, J-2, H-4, L-1, L-2, R-1, R-2, O-3, TN or TD VISA**? Yes ☐ No ☐

PRIMARY MEMBER INFORMATION

Please Print Clearly

Last Name:	First Name:	Middle Initial:	Gender: ☐ Female ☐ Male
Suffix (Sr., Jr., III):	**Social Security Number (REQUIRED):** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	**SLU Banner ID Number (REQUIRED):** ___ ___ ___ ___ ___ ___ ___ ___ ___	Date of Birth (month/day/year): ___ ___ / ___ ___ / ___ ___ ___ ___
Local Street Address:	Apt/Unit/Mailbox #:		
City:	State:	Zip Code:	
Home Phone (include Area Code): (_____) _____ - _____	Work Phone (include Area Code): (_____) _____ - _____		
Pager/Cell (include Area Code): (_____) _____ - _____	E-Mail Address:		
Expected month and year of graduation from Saint Louis University (**MM/YYYY**): ____ ____ / ____ ____ ____ ____			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Head of Household [*Unmarried Primary with one (1) Dependent Child*]	Coverage Desired: ☐ Single [*Primary only*] ☐ Double [*Primary + 1 Dependent (Spouse or Child)*] ☐ Family [*Primary + Spouse + Dependent Children*]		
Are you (or your covered dependents) enrolled in other health insurance? ☐ Yes ☐ No If yes, list all other carrier(s) and policy numbers:			
Other Carrier Address:	Other Carrier Phone Number:	Other Carrier Effective Date:	

LIST ADDITIONAL DEPENDENTS TO BE INCLUDED UNDER UNIVERSITY HEALTH PLAN COVERAGE

Last Name	First Name	Middle Initial	Sex	Birth Date	Social Security Number	Relationship	Other Coverage
						Spouse	☐ Yes ☐ No
						Child	☐ Yes ☐ No
						Child	☐ Yes ☐ No
						Child	☐ Yes ☐ No
						Child	☐ Yes ☐ No

RELEASE OF INFORMATION	
Release of Information Designee:	Release of Information Designee:

READ BEFORE SIGNING

I authorize any physician, hospital, medical practitioner or facility, insurance company, or person, that has any records or knowledge of my health or of any family member proposed for coverage, to furnish University Health Plan with any and all such information. I further authorize University Health Plan to release and obtain medical information to or from other appropriate agencies/providers for the purpose of providing necessary health care services and/or administrative services under the University Health Plan. ***I understand the benefits and hereby apply for membership.***

Signature: _____ Date: _____ / _____ / _____

UHP USE ONLY		
Group #:	Effective Date of Coverage:	Tentative End Date:
Reason for Enrollment: ☐ New Student/Housestaff Enrollment ☐ Open Enrollment ☐ Qualifying Event Explain:		
UHP Approval Signature:		Date:

Summer 2012 UHP Open Enrollment Dates: 05/20/12 – 06/30/12