

University of Denver
Student Health Insurance Plan (SHIP) Enrollment Form for
2009-10 Spring Quarter (201030)- Continuous Enrollment

1. Student Information

Student Name: _____
Last name First Name MI

DU Student ID#: _____ Date of Birth mm/dd/yy: _____ Male Female

U.S. Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Local Phone Number: _____

Email: _____ @du.edu
(emails will only be sent to an @du.edu account)

2. Enrollment Period

Please initial the dotted line that you understand the coverage dates.	\$1140	If you wish to enroll a dependent, please visit www.uhcsr.com
	Coverage Dates	
	____ ____ March 22, 2010 – August 31, 2010	
	Enrollment Deadline: April 02, 2010	

3. Payment Method

I pay for the premium. Personal Check or Money Order Make check or money order payable to DU.

My Financial Aid pays for the premium. Please charge the fee to my student account.

My Graduate Program pays for the premium. Please ask the person in your program who approved the payment to sign this form and enter the award into the Financial Aid System.

Budget Officer Name: _____ **Extension:** _____ **Date:** _____
Budget Officer Signature: _____

4. Notice to Student (Signature required)

I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. I permit the University of Denver to provide the United Healthcare with my enrollment status for purposes of eligibility under this plan. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company, or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Enrollment Guidelines: If the Dependent Application and Premium is received on or before the deadline date, coverage will be backdated to the beginning of the Policy Period for which coverage has been purchased. Applications received after the deadline date will not be accepted in the absence of a significant life change (i.e. involuntary loss of prior coverage).

Student Signature: _____ **Date:** _____

Form & payment must be received at: The DU Health & Counseling Center / 2240 E Buchtel Blvd 3N / Denver, CO 80208
Phone 303.871.2205 • Fax 303.871.4242

HCC OFFICE USE ONLY

Received by: Elizabeth • JD • Jill • Sarah • Melody • Erica • Other: _____	<input type="checkbox"/> Verify all sections are completed, initialed and signed <input type="checkbox"/> Verbally verify student understands coverage dates <input type="checkbox"/> Give a copy to the student <input type="checkbox"/> Verify Payment	Date	:	___/___/___
Processed by: Sarah • JD • Jill • Other: _____	<input type="checkbox"/> Verify student status in Banner <input type="checkbox"/> Scan <input type="checkbox"/> Complete Cashier Receipt <input type="checkbox"/> Submit to the Bursar within one business day	Date	:	___/___/___