Blue Cross Blue Shield Western New York Insurance Company

Return To: Suite 315 Student Union North Campus Buffalo, NY 14260 or FAX 716-645-3465 **Claims Administrator**

University at Buffalo- Student and Dependent Insurance Plan

2015/2016 Student Health Insurance Enrollment Form

In order to enroll you must complete steps 1 through 5!

Staff Use: Enrolled ☐	*Staff Use*: S/A Billed ☐	*Staff Use*: payment ☐ receipt #	*Staff Use: P/I* _____

1. Complete all Student information. Incomplete information will delay processing!

Contact Blue Cross Blue Shield 1-800-888-0757 or SMI Office at 716-645-3044 for assistance.

Student Name: _____ _____ _____
Last Name First Name MI

Student ID #:: ___ ___ ___ ___ — ___ ___ ___ ___

UB HUB PERMANENT ADDRESS WILL BE ENTERED AS DEFAULT

Email address: _____ @BUFFALO.EDU

Please print clearly

Phone Number: ( )_____- _____Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___ Sex: ☐ Male ☐ Female

2. Select Enrollment Plan

Form ID: BC/BS	A.	C.	D.	Cert. Creditable Coverage Proof of Term Date ☐
Basic Plan	Annual Effective Date: Aug. 22, 2015 - Aug. 21, 2016 Deadline: 10/14/2015	Spring/Summer Effective Date: Jan. 22, 2016 - Aug. 21, 2016 Deadline: 3/9/2016	Summer Effective Date: May 22, 2016- Aug. 21, 2016 Deadline: 6/22/2016	Off Cycle Effective Date: ___/___/___ - Aug. 21, 2016 Deadline: w/in 30 days
S= Student	☐ BB - $1,903.00	☐BB - $1,127.00	☐ BB - $ 506.00	☐ BB - $
S & Spouse	☐ BB - $3,806.00	☐ BB - $2,254.00	☐ BB - $1,012.00	☐ BB - $
S & Child	☐ BB - $3,363.00	☐ BB - $1,995.00	☐ BB -$ 901.00	☐ BB - $
S & FAMILY	☐ BB - $7,620.00	☐ BB - $4,495.00	☐ BB - $1,995.00	**Request Rate**

3. List Dependents to be insured. Dependent coverage is ONLY available if the student is covered. (Last name, first, DOB, gender)

	Last Name:	First Name	Date of Birth	Notes:	Gender
Spouse					M F
Child					M F
Child					M F
Child					M F

PLEASE COMPLETE AND SIGN THIS FORM. APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

4. Designate Payment Method: The premium will be added to your Bursar Bill. Students on Leave, Post Doc/Bach and LOA are required to pay by check or money order made payable to Sub Board One, Inc.

5. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit UB to provide Blue Cross Blue Shield with enrollment status for purposes of eligibility under this plan**. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) can be made void. I understand that if it is later determined that I am not eligible **(see the brochure, pamphlet or Master Policy for eligibility guidelines),** the premium will be refunded, but the premium is not refundable for reasons other than eligibility**.**

It is the student's responsibility for timely renewal payments.

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. Application to enroll late in the plan must be made within 30 days of loss of other coverage. A letter of creditable coverage from the prior insurance carrier must accompany the application.**

Signature:_____**Date**:_____