Underwritten by Europ Assistance USA

UNIVERSITY OF MIAMI STUDENT HEALTH INSURANCE PLAN

SCHOLAR, STUDENT, OBSERVER & DEPENDENT ENROLLMENT FORM

2017-2018 MEDICAL EVACUATION/REPATRIATION SCHOLAR, STUDENT, OBSERVER, AND DEPENDENT ENROLLMENT FORM

SCHOLAR/ STUDENT/ OBSERVER'S NAME	LAST / SURNAME		
	FIRST NAME		MIDDLE INITIAL
STUDENT I.D. #	DATE OF BIRTH (Month, Day, Year)	SOCIAL SECURITY # (U.S. Citizens and Permanent Residents only)	
U.S. MAILING ADDRESS (Use school address if none)	STREET		APARTMENT #
CITY	STATE	ZIP	
PHONE #	EMAIL ADDRESS (REQUIRED)		

Please check appropriate box: ❑ FEMALE ❑ MALE	**Please check appropriate box:** ❑ SINGLE ❑ MARRIED/DOMESTIC PARTNER	**Please check appropriate box:** ❑ INTERNATIONAL ❑ DOMESTIC	**Please check appropriate box:** ❑ UNDERGRADUATE ❑ GRADUATE ❑ SCHOLAR ❑ OBSERVER

PLEASE LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO ENROLLED IN THE SCHOOL PLAN.
(Dependents must be enrolled on the date the student is enrolled or within 31 days of date of birth, marriage, or arrival in U.S.)

LAST / SURNAME	FIRST NAME	MIDDLE INITIAL	GENDER	DATE OF BIRTH (Month, Day, Year)
SPOUSE/DOMESTIC PARTNER:			❑ Female ❑ Male	
CHILD:			❑ Female ❑ Male	
CHILD:			❑ Female ❑ Male	
CHILD:			❑ Female ❑ Male	
CHILD:			❑ Female ❑ Male	

NOTICE TO SCHOLAR/STUDENT/OBSERVER:

By signing, the scholar/student/observer acknowledges the following:

1. He/ She has carefully read the brochure and elects to enroll as indicated on this enrollment form;
2. Rates are not pro-rated;
3. He/ She meets the eligibility requirements for this coverage as described in the brochure;
4. If it is later determined that the scholar/student/observer/dependent is not eligible, the premium will be refunded;
5. Policy renewal is the responsibility of the scholar/student/observer/dependent and must be requested prior to the termination of the current policy to prevent a lapse in coverage.

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: *https://studentinsurance.wellsfargo.com* or call **800-853-5899** to request a paper copy free of charge.

PLEASE SEE OTHER SIDE FOR RATES AND PAYMENT INFORMATION. YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM. CALL (800) 853-5899 WITH QUESTIONS.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

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PROGRAM COSTS			
ANNUAL RATE AVAILABLE FROM: 8/15/17 - 8/14/18			
Scholar/Student/Observer only Rate	$62.00	x 1 =	$_____
Dependent enrollment in this plan is voluntary. Dependent coverage is in addition to student coverage.			
Spouse/Same Sex Domestic Partner only Rate	$62.00	x 1 =	$_____
Per Child only Rate (age 0-25)	$62.00	x _____ = # of children	$_____
		Total Premium:	= $_____ (add first three lines)

Rates include premium payable to Europ Assistance USA, as well as administrative fees payable to Wells Fargo Student Insurance.

Coverage is not automatically renewed. Please see the plan summary of benefits for complete benefits and contact information.

PAYMENT METHOD (Remit in US Funds Only)

NOTE: If we are unable to process your payment (due to insufficient funds, closure of account, etc.), you and/or your dependents' insurance coverage will be terminated retroactive to the effective date of the enrolled term and you will be responsible for any claims that you've incurred.

❑ **Check/Money Order –** MAKE CHECKS PAYABLE TO: Wells Fargo Student Insurance

❑ **Credit Card:** ❑ Visa ❑ MasterCard ❑ Discover

Credit Card Account Number:	Expires (month, year):
Cardholder's Name:	

(Enter/Print Cardholder's name exactly as it appears on card.)

Mail or fax enrollment form and payment to:
Wells Fargo Student Insurance, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670 • Fax (877) 612-7966

This is limited term coverage only. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated. Coverage begins at 12:01 am and ends at midnight. 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 or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

YOU MUST COMPLETE BOTH SIDES OF THE ENROLLMENT FORM AND SIGN BELOW

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements and I have read and understand the Plan Brochure. My signature below authorizes The University of Miami to provide Wells Fargo Student Insurance with required information necessary to validate my enrollment. I understand my information is protected by privacy laws and will be released only in accordance with these laws.

SIGNATURE OF SCHOLAR/STUDENT/OBSERVER _____ DATE _____

WELLS FARGO INSURANCE PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at (800) 853-5899 or by visiting us at studentinsurance.wellsfargo.com.