University Health Services • University of Massachusetts Amherst • HEALTH PLAN ENROLLMENT FORM

150 Infirmary Way • Amherst, MA 01003 • (413) 577-5192 • patientservices@uhs.umass.edu

INDIVIDUAL: Student name: _____
(Please print) (Last) (First) (M.I.)

Student ID#: _____ **D.O.B:** ____/____/____ **Gender:** _____
MM DD YY

Mailing address: _____
(Street) (City) (State) (Zip code)

Home telephone: _____ **Work telephone:** _____

Cell phone: _____ **Email address:** _____

Student status: _____ **# of credits this semester** _____
(i.e. undergrad, grad, CE)

Is this your first enrollment in family plan? Yes _____ **No** _____ **GEO eligible? Yes** _____ **No** _____

FAMILY PLAN: Family Plan members include spouse/same sex domestic partner (statement of partnership must be completed) and/or minor children under the age of nineteen. (If you have legal guardianship of a minor child, we need court documentation of the legal guardianship).

ADD FAMILY MEMBERS: **Date of Birth** **Gender**

Spouse/domestic partner: _____ ____/____/____ _____
(Last) (First)

Is spouse/domestic partner a student at UMass? Yes _____ **No** _____ **Student I.D.#:** _____

Child: _____ ____/____/____ _____
(Last) (First)

Child: _____ ____/____/____ _____
(Last) (First)

Child: _____ ____/____/____ _____
(Last) (First)

Child: _____ ____/____/____ _____
(Last) (First)

Child: _____ ____/____/____ _____
(Last) (First)

PAYMENT OF ANY PREVIOUS ENROLLMENT MUST BE PAID IN FULL OR RE-ENROLLMENT WILL NOT BE GRANTED.

- Cancellation of this coverage must be received in writing prior to Add/Drop Deadline of the semester, otherwise plan cancellation will not be granted.
- Charges for health plans are forwarded to the Bursar's office to be included in your tuition bill. Charges will be calculated in accordance with any waivers that are current including GEO waivers.
- Dates of coverage are listed below – it is your responsibility to enroll on a timely basis. Notices are not sent out to plan members.
- UHS determines eligibility and has the right to deny coverage if the members are not eligible.
- You must be enrolled in class or be on continuous enrollment in order to be eligible for this coverage.

SIGNATURE: _____ **Date:** _____

COVERAGE DATES:

Student Health Fee: _____ **To:** _____

Student Health Benefit Plan: _____ **To:** _____

Family Plan: _____ **To:** _____

FOR OFFICE USE ONLY

Enrollment reviewed by: _____ **Charges to Bursar's Office: $** _____
(initials)

Comments: _____

_____

_____

White: Patient Services ***Yellow: Patient***