

University of Massachusetts Amherst • HEALTH PLAN ENROLLMENT FORM
University Health Services • 150 Infirmary Way • Amherst, MA 01003 (413) 577-5192

PLEASE PRINT: Student Name: _____
(Last) (First) (M.I.)

Student ID#: _____ SS#: _____ D.O.B: ____/____/____ Male/Female: _____
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)

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).

	Date of Birth	M/F
Spouse/Domestic Partner: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____
Is Spouse/Domestic Partner a student at UMass? Yes _____ No _____	Student I.D.#: _____	
Child: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____
Child: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____
Child: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____
Child: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____
Child: _____ <small>(Last) (First)</small>	SS#: _____	____/____/____

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. **PLEASE NOTE COVERAGE DATES.**

GEO Eligible? Yes _____ No _____
 If UHS receives notification that I am not Eligible for the GEO health benefit, I understand that I will be billed for the full cost of the plans in which I have enrolled. It is the student's responsibility to find out if he or she is eligible prior to enrollment.

→ SIGNATURE: _____ **Date** _____

FOR OFFICE USE ONLY

Basic Plan:	Dates of Coverage: _____	To: _____	
Basic Plan:	Dates of Coverage: _____	To: _____	
Student Ins:	Dates of Coverage: _____	To: _____	
Family Plan:	Dates of Coverage: _____	To: _____	
Charge:	99606-Basic: _____	99607-SHIP: _____	99608-Family Plan: _____
Paid:	99606-Basic: _____	99607-SHIP: _____	99608-Family Plan: _____
Paid by:	Cash: _____	Credit Card: _____	Check#: _____
Payment Plan:	YES _____ NO _____	GEO FORM: _____	Payroll Deduction: _____
Comments: _____			
Date: _____ Enrollment Reviewed and Accepted by: _____ <small>(initials)</small>			