BRANDEIS UNIVERSITY

2023-2024 Dependent Qualifying Event Enrollment Form

STUDENT INFORMATION:

Student Name: (Last)_____ (First)_____ (MI)____ Date of Birth: _____ / _____ / _____

Student ID#: _____ Gender: ___ Email Address: _____Telephone #: ____ - ____ - _____

Mailing Address: (Street Address)_____

(City)_____ (State)_____ (Zip Code)_____

DEPENDENT INFORMATION:

Spouse's Name: (Last)_____ (First)_____ (MI)____ Date of Birth: ____ / ____ / ____ Gender: _____

Child's Name: (Last)_____ (First)_____ (MI)____ Date of Birth: ____ / ____ / ____ Gender: _____

Child's Name: (Last)_____ (First)_____ (MI)____ Date of Birth: ____ / ____ / ____ Gender: _____

Child's Name: (Last)_____ (First)_____ (MI)____ Date of Birth: ____ / ____ / ____ Gender: _____

ENROLLMENT INSTRUCTIONS: Refer to the table below for eligible enrollment reasons, required documentation and the deadlines. The effective date of your Blue Cross Blue Shield plan will be retroactively effective to the date noted in the table. **If your "reason for late enrollment" is not listed below or if the deadline has passed, you are not eligible to enroll at this time and must wait until the next policy year which will start Fall 2023.**

Person To Be Enrolled	Reason for Late Enrollment	A copy of the following documentation is required.	UHP must receive the completed enrollment form and appropriate documentation within:	The effective date of the BCBS coverage will be:
Spouse	Involuntary Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	The date of prior coverage termination.
Spouse	Entry into U.S.	Identification page of Passport and page with U.S. entry date stamp	60 days following date of entry into the U.S.	the date of entry into the U.S.
Spouse	Marriage to Student	Marriage certificate	60 days following date of marriage.	The date of marriage.
Child(ren)	Involuntary Termination of Prior Coverage	Insurance document showing the date of termination	60 days following prior coverage termination.	The date of prior coverage termination.
Child(ren)	Birth	Birth certificate, if available	60 days following date of birth.	The date of birth.
Child(ren)	Adoption	Official adoption papers showing date of adoption	60 days following adoption.	The date of adoption.

PREMIUM INFORMATION: Please contact University Health Plans for information about premium that you need to include with this form. ***Please note Credit Card payments are not accepted. Payment should be made in the form of a Personal Check, US Bank Check or US Money Order payable to RSC Insurance Brokerage, Inc.***

MAILING INSTRUCTIONS: Mail the completed enrollment form, payment and a copy of the required supporting documentation (refer to table above) to: *University Health Plans, 15 Pacella Park Drive, Suite 130, Randolph, MA 02368.* You will receive an insurance card approximately 10 business days after all enrollment documentation is received by University Health Plans.

ENROLLMENT REQUIREMENTS CHECKLIST:

- ☐ Complete this form.
- ☐ Include the required documentation (see above table). ALL enrollments require something in addition to this form. Your enrollment request **cannot** be processed without it.
- ☐ Contact University Health Plans for premium rates.
- ☐ Include check/money order made payable to University Health Plans. Please contact University Health Plans for details.

Student Signature: _____ Date: _____

If you have any questions, please contact University Health Plans at 833-251-1737 or info@univhealthplans.com.