WAYNE STATE UNIVERSITY

2023-2024

Visiting Scholars

HEALTH INSURANCE ENROLLMENT FORM

Please complete the information on all pages. Print clearly and answer all questions thoroughly, as incomplete forms will not be accepted.

SCHOLAR INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

WSU STUDENT/SCHOLAR ID NUMBER	EMAIL ADDRESS

US MAILING ADDRESS	APT NO:

CITY	STATE	ZIP

PHONE NUMBER	DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH
		◯ MALE ◯ FEMALE

DEPENDENT INFORMATION, IF APPLICABLE
List Dependents to be insured. Dependent coverage is available only if the student is covered.

	LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH
SPOUSE/DOMESTIC PARTNER					◯ MALE ◯ FEMALE
CHILD					◯ MALE ◯ FEMALE
CHILD					◯ MALE ◯ FEMALE
CHILD					◯ MALE ◯ FEMALE

SELECT THE COVERAGE AND CALCULATE THE TOTAL CHARGES.
Note: You must purchase a minimum of 30 days of coverage unless the period of time in the U.S. is less. As a Visiting Scholar you are required to maintain the Scholars Health Plan sponsored by Wayne State University for the entire period you will be in the U.S. as a Visiting Scholar of Wayne State University. Premium charges for less than full months of coverage not pro-rated. You will be billed a full month of premium.

Multiply the rate and number of covered individuals to get your total premium.

	MONTHLY RATE	# OF	TOTAL	DATES OF COVERAGE REQUIRED (Must be the full period of time in the U.S.)
STUDENT	$ 171.19	x	= $	
SPOUSE/DOMESTIC PARTNER	$ 171.19	x	= $	
ONE CHILD	$ 171.19	x	= $	
TWO OR MORE CHILDREN	$ 340.29	x	= $	
TOTAL AMOUNT DUE			**= $**	

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Please fill in the dates for which you are requesting coverage.
Dependents cannot be enrolled beyond the primary insured coverage dates.

EFFECTIVE DATE (MM/DD/YYYY) _____

TERMINATION DATE (MM/DD/YYYY) _____

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Coverage dates may not extend beyond AUGUST 15, 2024.

New rates will apply after this date.

REMIT PAYMENT IN U.S. FUNDS ONLY.

COMPLETE CREDIT CARD INFORMATION BELOW.

Credit Cards Accepted: VISA, MASTERCARD, DISCOVER

Credit card authorization charge will appear as **"BLUE WATER BENEFITS"** on the credit card statement.

CREDIT CARD # | | | | | | | | | | | | | | | | |

EXPIRES (MM/YY) \

CSV CODE*

* The credit card security code, known as a CSV of CID code, is the three-digit number printed on the back of your card, usually to the right of the signature field.

NAME OF CARDHOLDER (PLEASE PRINT)

CHARGE AMOUNT $

CARDHOLDER'S BILLING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)

APT NO:

CITY

STATE

ZIP

COUNTRY

By signing below, I authorize my credit card to be charged the amount listed above for the coverage selected under the Michigan State University Student Health Insurance Plan.

I ACCEPT THE FOLLOWING CANCELLATION / REFUND POLICY.

There are no premium refunds, except when the Plan participant enters the armed forces of any country, or it is determined that the student is not eligible for coverage and there are no claims on file. A refund request must be sent in writing to **SHIP_ENROLLMENT@BLUEWATERBENEFITSADMIN.COM** with reason for cancellation. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to the approval of Wayne State University and/or Blue Water Benefits Administrators.

CARDHOLDER SIGNATURE

DATE (MM/DD/YYYY)

ENROLLMENT GUIDELINES

Scholars who voluntarily enroll themselves and their dependents as well as will not receive notification prior to the deadline reminding them to reenroll. It will be the responsibility of the scholar to reenroll him or herself and dependents. Failure to reenroll prior to the deadline will result in a break in coverage. Coverage may not extend beyond July 31, 2024. If you are eligible for additional coverage, new rates may apply.

The information contained on this form is confidential and will not be released unless the student named in this form provides written authorization, except to comply with state or federal law or a court order. This information may also be released in the event of an emergency hospitalization, or in other circumstances which pose a threat to life or serious immediate physical harm.

I HAVE CAREFULLY READ THE PLAN DESIGN AND BENEFIT SUMMARY INFORMATION AND ELECT TO ENROLL AS INDICATED. RATES ARE NOT PRO-RATED OTHER THAN AS LISTED. I PERMIT WAYNE STATE UNIVERSITY TO PROVIDE BLUE CROSS BLUE SHIELD OF MICHIGAN WITH MY 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 DEPENDENTS CAN BE MADE VOID. I UNDERSTAND THAT IF IT IS LATER DETERMINED THAT THE STUDENT IS NOT ELIGIBLE FOR COVERAGE, THE PREMIUM WILL BE REFUNDED, BUT THE PREMIUM IS NON-REFUNDABLE FOR REASONS OTHER THAN ELIGIBILITY.

SCHOLAR SIGNATURE

DATE (MM/DD/YYYY)

RETURN THIS FORM TO: SHIP-ENROLLMENT@BLUEWATERBENEFITSADMIN.COM

If there are any discrepancies between this document and the Plan Certificate, the Plan Certificate will govern.