UCONN UNIVERSITY OF CONNECTICUT | BAILEY AGENCIES INSURANCE | CHP Consolidated Health Plans A Berkshire Hathaway Company

2016-2017 HEALTH INSURANCE PRO-RATED ENROLLMENT FORM-VISITING SCHOLARS

Effective Date:

STUDENT ONLY: **$273.00 x _____ # of months needed + $70 (Broker Fee) = $ _____ Total Payable**
(minimum 1 month)
ONE DEPENDENT: **$273.00 x_____ # of months needed + $70 (Broker Fee) = $ _____ Total Payable**
(ADDITIONAL)
TWO DEPENDENTS: **$546.00 x _____# of months needed + $140 (Broker Fee) = $ _____ Total Payable**
(ADDITIONAL)
FAMILY (3+ DEP): **$819.00 x_____ # of months needed + $210 (Broker Fee) = $ _____ Total Payable**
(ADDITIONAL)

LAST NAME _____FIRST NAME: _____ MI _____

DATE OF BIRTH: _____STUDENT ID#: _____ GENDER: MALE **or** FEMALE

SOCIAL SECURITY #: _____/_____/_____ UCONN Email: _____

U.S. ADDRESS:_____

CITY:_____STATE:_____ ZIP _____

CAMPUS: UCONN/STORRS **UCONN/**REGIONAL **PHONE: _____**

Enter Dependent Information Here:

SPOUSE:

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

CONTINUED ON THE BACK:

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

DEPENDENT CHILD

LAST NAME: _____ FIRST NAME: _____ MI_____

DATE OF BIRTH: _____SSN# _____ GENDER: MALE FEMALE

Acknowledgements:
By my signature here:

I acknowledge that I have reviewed the coverage available under the Student Health Insurance Plan offered by the University of Connecticut through Consolidated Health Plans (CHP).

I acknowledge that once enrolled I will be unable to request cancellation of this coverage and once enrolled the coverage will remain in effect until the expiration date of the requested enrollment period noted on this form.

I acknowledge and accept all of the above and request enrollment in the UCONN Student Health Insurance Plan.

_____ _____

STUDENT SIGNATURE **DATE**

PLEASE MAIL PAYMENTS TO:
Bailey Agencies, Inc., 15 Thames Street, Groton, CT 06340

MAKE CHECKS PAYABLE TO: UCONN HEALTH PLAN

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BAILEY AGENCIES USE ONLY

☐ Sent to Enrollment/CHP

☐ Logged Bailey Excel List- Master

☐ Logged Bailey List – EPIC

☐ Confirmed by CHP

☐ Invoiced

☐ Invoice Report/ VM

☐ Sent Temporary ID card

Notes: _____

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Rev. 05/2016