LifeWise Assurance Company

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Spokane, WA 99220

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UNIVERSITY of WASHINGTON

INTERNATIONAL STUDENT HEALTH INSURANCE POLICY
ENROLLMENT AND CHANGE FORM

1. PERSONAL INFORMATION

Student name (Last) (First) (MI)	Student ID	Phone ( )	E-mail address

Home address	City	State	ZIP	Mailing address (if different than home address)	City	State	ZIP

2. PLAN CHOICE (You must re-enroll every fall quarter regardless of previous coverage status)

Enrollment Period – Quarterly Options

☐ Autumn ☐ Winter ☐ Spring ☐ Summer

Enrollment Period – Annual Options

☐ Annual starting in Autumn (4 Qtrs) ☐ Annual starting in Winter (3 Qtrs) ☐ Annual starting in Spring (2 Qtrs)

3. ENROLLMENT INFORMATION

Reason for Add or Drop (New enrollment, birth, marriage, divorce, etc.)	Date of Event / /	*NOTE: Please indicate each enrollee's name. ID card names are limited to 26 characters and spaces.*

Add	Drop	Relationship to Student	Last Name	First Name	MI		Date of Birth	Gender: Male	Gender: Female
☐	☐						/ /	☐	☐
Ethnicity (Optional)		(Check All That Apply) ☐ American Indian ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander	Check All That Apply) ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other__________		Secondary Language ☐ English ☐ Spanish ☐ Other_________			

Add	Drop	Relationship to Student	Last Name	First Name	MI		Date of Birth	Gender: Male	Gender: Female
☐	☐						/ /	☐	☐
Ethnicity (Optional)		(Check All That Apply) ☐ American Indian ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander	Check All That Apply) ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other__________		Secondary Language ☐ English ☐ Spanish ☐ Other_________			

Add	Drop	Relationship to Student	Last Name	First Name	MI		Date of Birth	Gender: Male	Gender: Female
☐	☐						/ /	☐	☐
Ethnicity (Optional)		(Check All That Apply) ☐ American Indian ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander	Check All That Apply) ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other__________		Secondary Language ☐ English ☐ Spanish ☐ Other_________			

Does a dependent have a different mailing address? ☐ No ☐ Yes If yes, complete the following: Dependent's Name _____

Dependent's mailing _____ City _____ State _____ ZIP _____

Is any child age 26 or over enrolling for coverage due to disability? ☐ No ☐ Yes. Complete and attach a *Request for Certification of Disabled Dependent* form.

Has any enrollee had health insurance coverage at any time during the past 3 months before your enrollment date on this plan?

☐ No ☐ Yes If yes, who was covered? ☐ Student ☐ Dependent Children
☐ Spouse / Registered Domestic Partner (We are either both of the same sex or one of us is at least 62 years of age) Date coverage began / / Date coverage ended / /

Will any enrollee have other current health coverage including Medicare, which will remain in effect when your LifeWise coverage begins?
☐ No ☐ Yes, please complete and attach an *Other Coverage Questionnaire* form.

4. STUDENT SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted.

Student signature _____ Date signed _____ / _____ / _____

Please note: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

CONDITIONS OF ENROLLMENT/SIGNATURE

Please make sure you understand your school's credit hour and other requirements for enrolling in this plan as described in the plan brochure available on the university's website.
By accepting this Conditions of Enrollment/Signature I attest that I am eligible for this coverage and that I authorize the university to provide LifeWise Assurance Company (LifeWise) with my enrollment status to validate eligibility under the plan. LifeWise reserves the right to review, at any time, that the eligibility requirements for enrollment have been met. If it is determined that you do not meet the school's eligibility requirements for enrollment or you have performed an act or practice that constitutes fraud, your coverage may be voided (voided means to cancel coverage back to its effective date, as if it had never existed at all). If coverage is voided, payments made by the plan shall be recoverable by the plan. Premium is not refundable for any reason other than a determination of ineligibility or unless you, your spouse, or your domestic partner enters the military service on full-time active duty.
I understand and agree that submission of this enrollment information and/or premium payment does not guarantee coverage. Rates are limited to the options listed and are not pro-rated. I authorize LifeWise, at its option, to pay providers directly for services rendered.
I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PRIVACY POLICY

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other health-care plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.
To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.
You have the right to request inspection and/or amendment of your records retained by us.
To view or print copies of our detailed Privacy Notice, please visit our web site at student.lifewiseac.com. To have forms mailed to you, please call the number below.

NEWLY ACQUIRED DEPENDENTS

You must enroll your newly acquired dependent within 30 days of marriage or domestic partner registration or within 60 days of birth or placement for adoption in order to enroll them at any other time than when you are purchasing coverage.

REQUIRED SOCIAL SECURITY NUMBER AND CONTACT EMAIL ADDRESS

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2017. You'll need Form 1095-B to help you file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 800-971-1491

Underwritten by LifeWise Assurance Company 7007 - 220TH SW, Mountlake Terrace, WA 98043