Anthem. STUDENT ADVANTAGE

WRIGHT STATE UNIVERSITY
Boonshoft School of Medicine
Request to be added to Student Health Insurance Plan (SHIP)

2021-2022 ACADEMIC YEAR

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	SCHOOL ID #:
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)		
CITY:	STATE:	ZIP CODE:
TELEPHONE #:	EMAIL ADDRESS:	

DEPENDENT INFORMATION Complete information below for dependents to be insured. Dependent coverage is only available for students insured under the Plan (Please include a blank sheet for additional dependents).		
SPOUSE:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:

NOTICE TO STUDENT: This request is made to the University representatives who are responsible for determining eligibility for inclusion on the list of enrollees provided to Anthem Blue Cross Blue Shield.

Student's Signature: ______________________________ Date: ______________

WRIGHT STATE
BOONSHOFT SCHOOL OF MEDICINE

☐ **I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made. I understand that the Cost of the plan below may change depending on and subject to the review and approval of the rates by the Ohio Insurance Department.**

		Annual	Fall	Spring/Summer
1	Student	☐ $ 3,156.00	☐ $ 1,578.00	☐ $ 1,578.00
2	Spouse/Domestic Partner	☐ $ 3,156.00	☐ $ 1,578.00	☐ $ 1,578.00
3	Each Child	☐ $ 3,156.00	☐ $ 1,578.00	☐ $ 1,578.00

PLEASE CHECK THE APPROPRIATE BOX:

MEDICAL SCHOOL YEAR **1** ☐ **2** ☐ **3** ☐ **4** ☐

EFFECTIVE/EXPIRATION PERIODS:

☐Annual 7/01/2021 to 6/30/2022
☐Fall 7/01/2021 to 12/31/2021
☐Spring/Summer 1/01/2022 to 6/30/2022

Email this form to:

Nancy Caupp
Program Coordinator
nancy.caupp@wright.edu