HEALTH INSURANCE INFORMATION FORM

Date:

First Name:

Last Name:

E-mail:

Return form to SHIP Office: Student Health Building Room 129
Mail to: 875 Perimeter Dr MS 4203; Moscow ID 83844-4203
Fax Number: 208-885-1002 **E-mail:** health@uidaho.edu

Student ID Number:

☐ FALL ☐ SPRING ☐ SUMMER

☐ 2020 ☐ 2021 ☐ Other _____

IF SEMESTER HAS NOT BEGUN THE HEALTH INSURANCE INFORMATION FORM MUST BE SUBMITTED IN VANDALWEB.

The health insurance requirements or substantial compliance standards below must be confirmed by checking the box.

☐ **YES** My personal health insurance covers illness, injury, mental health and prescription services; AND emergency and non-emergency services in the Moscow/Pullman area or area of program.

☐ **YES** My personal health insurance will be effective on or before the first day of the semester indicated above; OR meets the substantial compliance standards outlined in the health insurance requirement at www.uidaho.edu/studentinsurance.

☐ **YES** I understand that I must maintain active & continuous compliant health insurance to be enrolled in 12 or more undergraduate credits OR 9 or more graduate/Law credits, & that noncompliance will result in automatic enrollment in SHIP;

☐ **YES** I also acknowledge that if I drop, lose or change insurance during the academic year I must notify the UI SHIP Office within 30 days to provide new policy information or enroll in SHIP. *See website for late enrollment form and instructions.*

OPTIONAL REQUIREMENTS:

☐ **YES** I have insurance that covers injury while participating in intramural, club, or NCAA intercollegiate sports programs.

☐ **NO** I will NOT be participating in intramural, club or NCAA intercollegiate sports programs.

SIGN HERE: ***Student signature required for processing.***

REQUIRED INSURANCE INFORMATION--*Please include all prefix letters and numbers for policy information.*

Insurance Company Name:

Insurance Company Customer Service Phone Number:
NOTE: MUST BE U.S. BASED PHONE NUMBER

Insurance Policy/Individual/Subscriber Number:

Insurance Group or Employer Number (if applicable):

POLICY HOLDER INFORMATION-- *for the primary insured person (parent or spouse if student is the dependent):*

First and Last Name: Date of Birth:

☐ Male ☐ Female **Student relationship to policy holder:** ☐ Self ☐ Child ☐ Spouse

Employer:

HEALTH INSURANCE VERIFICATION AND COMPLIANCE

The University of Idaho reserves the right to verify your health insurance information at any time during the year. The information you provided will be forwarded to an auditor for verification of compliance. The credit on your student account for medical insurance is conditional pending verification of compliance. If you are discovered to be uninsured or have insurance that does not meet the minimum requirements you will be enrolled in SHIP and the semester charge for medical insurance will be placed on your student account.

DATE FORM IS SUBMITTED

Form submitted AFTER first day of classes for semester indicated:

Form submitted AFTER policy year has ended must include a separate letter detailing circumstances of missed waiver deadline and a letter or certificate of coverage from the insurance company stating the effective date of the policy.

REFUNDS/FEES

100% refund **and** $100 penalty fee

50% refund if appeal is approved