

ROCKHURST UNIVERSITY
STUDENT HEALTH INSURANCE PLAN

Complete the information below. Please print clearly and answer **all** questions, then mail to the address listed below. Incomplete forms will not be accepted. For questions about enrollment, please contact Relation Insurance Services at (800) 955-1991.

1. ENTER STUDENT INFORMATION:

STUDENT'S LAST NAME		STUDENT'S FIRST NAME		MI
STUDENT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)				APT/UNIT #
CITY			STATE	ZIP
STUDENT'S DATE OF BIRTH (MM/DD/YYYY)		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	STUDENT'S PHONE NUMBER	STUDENT'S SCHOOL ID NUMBER
STUDENT'S EMAIL ADDRESS		OK TO CONTACT YOU VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO		STUDENT'S SOCIAL SECURITY NUMBER — —
ARE YOU AN INTERNATIONAL STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT IS YOUR HOME COUNTRY OR COUNTRY OF REGULAR DOMICILE?			PASSPORT VISA TYPE: <input type="checkbox"/> F1 <input type="checkbox"/> J1 <input type="checkbox"/> OTHER _____

2. SELECT THE COVERAGE YOU WISH TO PURCHASE AND CALCULATE THE TOTAL CHARGES:

DEPENDENT COVERAGE PERIOD MUST BE THE SAME AS THE STUDENT'S COVERAGE PERIOD.

	FALL 08/01/2021 to 12/31/2021	SPRING / SUMMER 01/01/2022 to 07/31/2022	SUMMER 06/01/2022 to 07/31/2022
SPOUSE	<input type="checkbox"/> \$ 2,434.85	<input type="checkbox"/> \$ 3,409.99	<input type="checkbox"/> \$ 975.14
ONE CHILD	<input type="checkbox"/> \$ 2,203.10	<input type="checkbox"/> \$ 3,085.54	<input type="checkbox"/> \$ 882.44
TWO OR MORE CHILDREN	<input type="checkbox"/> \$ 2,205.10	<input type="checkbox"/> \$ 3,089.54	<input type="checkbox"/> \$ 884.44
FAMILY	<input type="checkbox"/> \$ 3,133.90	<input type="checkbox"/> \$ 4,391.06	<input type="checkbox"/> \$ 1,257.16
TOTAL AMOUNT DUE	= \$	= \$	= \$

The cost of coverage includes medical insurance premium and administrative fees.

3. COMPLETE DEPENDENT INFORMATION ON PAGE 2 OF THIS FORM. THIS SECTION MUST BE COMPLETED FOR ENROLLMENT TO BE ACCEPTED. DEPENDENTS MAY BE ENROLLED IN THE PLAN ONLY IF THE STUDENT IS ALSO ENROLLED IN THE PLAN.**4. REMIT PAYMENT IN U.S. FUNDS ONLY. MAKE CHECK OR MONEY ORDER PAYABLE TO: RELATION INSURANCE SERVICES OR COMPLETE CREDIT CARD INFORMATION BELOW.**

CREDIT CARD AUTHORIZATION: CHARGE WILL APPEAR AS "STUDENT HEALTH INSURANCE, RELATION" ON YOUR CREDIT CARD BILL.														
CREDIT CARD #														EXPIRATION DATE ____/____/____
NAME OF CARDHOLDER (PLEASE PRINT)										CHARGE AMOUNT: \$	CSV/CID CODE:			
By signing below, I authorize my credit card to be charged the amount listed above for the coverage I have selected under the Rockhurst University Student Health Insurance Plan.														
SIGNATURE OF CARDHOLDER														

5. STUDENT SIGNATURE:

I certify that I am enrolled at Rockhurst University. By signing below, I acknowledge that I have read and understand the information contained in the Rockhurst University Student Health Insurance Plan Certificate and elect to enroll my dependent(s) for the coverage specified above.

SIGNATURE _____ DATE _____

6. RETURN THIS FORM WITH PAYMENT TO: RELATION INSURANCE SERVICES, PO BOX 25936, OVERLAND PARK, KANSAS 66225

COMPLETE DEPENDENT INFORMATION BELOW:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	GENDER
SPOUSE/DOMESTIC PARTNER				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CHILD				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

DEPENDENTS MAY BE ENROLLED IN THE PLAN ONLY IF THE STUDENT IS ALSO ENROLLED IN THE PLAN. Dependents must be enrolled on the date the student enrolls or within 31 days of marriage, birth, adoption or placement for adoption, arrival in the U.S., or ineligibility under another creditable coverage.

Newly acquired dependents (spouse and/or children) are not subject to the enrollment deadline dates. However, enrollment and premium payment for all newly acquired dependents (spouse and/or children) must be submitted within 31 days of marriage, birth, adoption or placement for adoption, or arrival in the U.S. (Proof of date of arrival in the U.S., birth, adoption, or marriage may be requested). **Otherwise, enrollment cannot be accepted after the enrollment deadline dates.**

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