ASHLAND UNIVERSITY DEPENDENT ENROLLMENT FORM

Eligibility: Dependents of full-time university students are eligible to enroll in the Student Health Insurance Plan. The dependent must be enrolled in the same time period as the student.

Please Check Appropriate Box(es):

___Undergraduate Student ___Graduate Student ___ Seminary Student ___ Bachelor's Plus Student ___ Accelerated Nursing Student
___ Domestic Student ___ International Student

This form is to be used only to enroll dependents of students whose types are noted above.

(Please Print)

Student Name: _____
First MI Last

Permanent US Address: _____
Street City State Zip

Student ID#: _____ **Social Security#:** _____ **Date of Birth:** _____ /_____ /_____

Gender: ___Male ___Female **Phone :** _____ **Email address:** _____

I would like to participate in the Ashland University's Dependent Plan for the following coverage period. Dependents must be enrolled for the same time period as the student.

Plan II-SHIP-Dependent Only - (Please List Dependents Below)

(Please check appropriate time period/premium)

	Annual Premium	Fall Premium	Spring/Summer Premium	Summer Premium
Time Period	**(8/12/25-8/11/26)**	**(8/12/25-1/1/26)**	**(1/1/26-8/11/26)**	**(5/1/26-8/11/26)**
___Spouse Only	____$1,810.00	____$705.00	____$1,105.00	____$511.00
___ Per Child	____$1,810.00	____$705.00	____$1,105.00	____$511.00
Enrollment Postmark Deadline	**9/29/25**	**9/29/25**	**2/9/26**	**6/8/26**

List dependents to be insured below. Dependent coverage is available only if the student is insured under the Plan. Note that dependents are not included in the Accident Only Coverage nor may they utilize the services of the Student Health Center.

(Please complete all required information)

	First Name/MI	Last Name	Date of Birth	Social Security Number	Gender
Spouse:					Male/Female
Child:					Male/Female
Child:					Male/Female

NOTICE: Coverage will be effective the first day of the term provided the premium is received by the Business Office, 202 Founders Hall, before the Deadline for enrollment. Once premium has been paid, there is NO REFUND unless the student was ineligible for coverage when they first enrolled in the Plan.

I hereby authorize Ashland University to add the premiums to my student account.

Signature: _____ **Date**: _____
(Student, Parent, or Guardian)

Please view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: www.wellfleetstudent.com to request a paper copy free of charge.

INSURANCE PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or visiting www.wellfleetstudent.com.