ASHLAND UNIVERSITY DEPENDENT ENROLLMENT FORM

Academic year 2026-2027

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 the appropriate box or boxes:

[ ] Undergraduate student [ ] Graduate student [ ] Seminary student
[ ] Bachelor's Plus student [ ] Accelerated Nursing student
[ ] Domestic student [ ] International student

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

Student information

(Please print.)

Student name:

First _____ Middle initial ____ Last _____

Permanent U.S. address: Street _____

City _____ State _____ ZIP code _____

Student ID number: _____ **Social Security number:** _____

Date of birth: ____ / ____ / _____ **Gender:** [ ] Male [ ] Female

Phone: _____ **Email address:** _____

Coverage selection

I would like to participate in 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 check the appropriate time period/premium.) Time Period: select one coverage column.

Coverage type	Annual premium (8/12/26-8/11/27)	Fall premium (8/12/26-1/1/27)	Spring/Summer premium (1/1/27-8/11/27)	Summer premium (5/1/27-8/11/27)
[ ] Spouse only	$2,391.00	$930.00	$1,461.00	$675.00
[ ] Per child	$2,391.00	$930.00	$1,461.00	$675.00
Enrollment postmark deadline	**9/28/26**	**9/28/26**	**2/8/27**	**6/7/27**

Dependent information

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.)

Relationship	First name / MI	Last name	Date of birth	Social Security number	Gender
Spouse	_____	_____	_____	_____	Male / Female
Child	_____	_____	_____	_____	Male / Female
Child	_____	_____	_____	_____	Male / Female

Notice and authorization

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: _____

(Student, parent, or guardian)

Date: _____

Summary of Benefits and Coverage

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.