ASHLAND UNIVERSITY VOLUNTARY ENROLLMENT FORM

Academic year 2026-2027

Eligibility

Voluntary Students are eligible to participate in the Student Health Insurance Plan if so determined by the Student Accounts Office. Students must enter the plan during their first regular term of the academic year in which they are eligible. Otherwise, they must wait until the following policy year. In order for a student to remain covered after the effective date of coverage, the Student must actively attend classes for at least 31 days.

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 for eligible students whose types are noted above.

Student information

(Please print.)

Name of student: 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 the Ashland University's Student Health Insurance Plan for the following coverage period:

Plan II-SHIP - Student Only

Please check the box for the appropriate time period and premium.

Coverage option	Coverage dates	Student-only premium	Enrollment postmark deadline
[ ] Annual premium	8/12/26 - 8/11/27	$2,559.00	9/28/26
[ ] Fall premium	8/12/26 - 1/1/27	$1,014.00	9/28/26
[ ] Spring/Summer premium	1/1/27 - 8/11/27	$1,545.00	2/8/27
[ ] Summer premium	5/1/27 - 8/11/27	$724.00	6/7/27

Coverage 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.

2026-2027