

# University Health Insurance Plan (UHIP) Enrollment Form



**PLEASE PRINT CLEARLY:**

A. Carleton Student Number: \_\_\_\_\_

Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
(dd/mm/yy)

Ottawa address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

**B. Complete this section only if your dependents (spouse and/or children) are with you in Canada:**

Dependents' date of arrival in Canada: \_\_\_\_\_ Length of Coverage Requested: \_\_\_\_\_ month(s)  
(YYYY/MM/DD)

Family Name	First Name	Relationship		Gender M/F	Date of Birth YYYY/MM/DD
		Spouse	Child		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		

C. I am a:

- International Student with domestic status/paying domestic fees
- Adding dependents
- Change from domestic to international
- OHIP waiting period (must provide proof)
- Graduation pending
- Other (explain) \_\_\_\_\_

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I authorize Cowan Assurance Company of Canada (the insurer), its agents and service providers and the UHIP® plan administrator to use and exchange relevant information about me in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage. The insurer is committed to keeping this information confidential.

I understand that UHIP® is compulsory and I am responsible for enrolling my dependents on my date of arrival. If, however, my dependents arrive at a later date, I must enroll them within 30 days of their date of arrival in Canada. Otherwise, I will have to pay a late application fee of \$500 and premiums retroactive to their date of arrival. I confirm that I am authorized to disclose information about my spouse and dependents in order to enroll them in this plan.

By signing below, I release the University from any responsibility for any undeclared dependents and for health care costs incurred by me or any of my dependents that are not eligible for reimbursement by UHIP® or a pre-approved plan. I understand that the University will accept no financial liability for any such costs.

A photocopy or electronic version of this authorization is as valid as the original and will remain in effect for the duration of my coverage under the UHIP® Plan.

Personal information collected through this form will be used and disclosed by Carleton University under the authority of the *Carleton University Act, 1952*, and in accordance with sections 39, 41 and 42 of Ontario's *Freedom of Information and Protection of Privacy Act*. The purpose of this processing is enroll you into the University Health Insurance Plan (UHIP).

The information will be used internally by International Student Services Office to manage the plan. Some information will be disclosed to Cowan Financial, the insurance plan administrator, in order for you to process benefits claims.

If you have any questions about the processing of personal information by International Student Services Office, please contact the Manager, Privacy & Access to Information, by phone at 613-520-2600 ext. 2047 or by e-mail via [University\\_Privacy\\_Office@carleton.ca](mailto:University_Privacy_Office@carleton.ca).

\_\_\_\_\_

\_\_\_\_\_

Date

Member's Signature

**FOR OFFICE USE ONLY:**

Premium Paid/Owing: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Termination date: \_\_\_\_\_

Length of Coverage \_\_\_\_\_ (months)

Number of Dependents: \_\_\_\_\_

Date processed: \_\_\_\_\_

Signature: \_\_\_\_\_