LA ROCHE UNIVERSITY

2022-23 SHIP
Student Health Insurance Plan
Enrollment/Waiver Form

❒ **ENROLL** I want to *enroll* in the 2022-23 La Roche SHIP.

One-year Term Effective dates: **08/1/2022 - 7/31/2023**
Total Cost of Insurance: **$1,850**
Includes one-time administrative fees.
Dependent spouse or child(ren) can be added for an additional cost. Email QM Services for more information,
university@qmservicesinc.com

Please fill in ALL required information:

Student Name _____

Student ID # _____

Social Security Number # _____

Student Date of Birth _____

Gender: ❒ M ❒ F

Student Cell Phone # _____

La Roche E-mail address _____

Alt E-mail address(es)_____

Home Country if different than USA_____

Please provide your preferred mailing addresses for all SHIP communications,

Street Address _____

City _____ State _____ Zip _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. 18 Pa C.S. A § 4117(k)(1)

_____ _____
Signature Date

❒ **WAIVE** I want to *waive* the 2022-23 La Roche SHIP and remove the charge from my student account.
Form must be returned with copy of front and back of insurance card.
ALL INTERNATIONAL STUDENTS must email insurance policy with exclusions and policy effective dates to anne.kocsis@qmservicesinc.com

Please fill in ALL required information (*if applicable):

Student Name _____

Student ID # _____

Student Cell Phone # _____

E-mail address _____

Insurance Company Name _____

Is this Medicaid? ❒ Yes - In which state? _____
Medicaid is government-funded and offers emergency-only benefits outside the state of residence.

Is this an HMO? ❒ Yes - from which state? _____
Contact your carrier to find out if your plan requires the use of a Primary Care Physician and if network providers are available away from home.

Who subscribes to the insurance?
Name _____

Relationship to Student _____ Date of Birth _____

Subscriber ID # _____

*Group # _____

Member Service Phone # _____

Claims Address (listed on card):
P.O. Box/Street Address _____

City _____ State _____ Zip _____

Is prescription coverage included? ❒ Yes ❒ No

*Pre-certification Phone # (back of card) _____

I hereby waive rights to the benefits of the La Roche SHIP. I have confirmed that my plan will cover my medical expenses while at school. If the insurance company specified on this form fails to pay, I understand that I will be solely responsible for all medical expenses.

_____ _____
Signature Date

QM SERVICES

Please return the completed form to QM Services:
*Secure Upload: **www.qmservicesinc.com** / Fax: **717-591-2093** or mail:*
La Roche University, c/o Student Insurance Administrator,
P.O. Box 867 • Mechanicsburg, PA 17055
If waiving the SHIP, include a copy of front and back of insurance card