ahp Academic HealthPlans℠

187083-16 - Dental

University of Houston-Downtown 2016 - 2017 Fall Student Dental Insurance Enrollment Form

DOMESTIC AND INTERNATIONAL STUDENTS

Enrollment will NOT be accepted after the Open Enrollment Period
(see reverse side for details)

(PLEASE PRINT CLEARLY or TYPE)

STUDENT INFORMATION									
Student Name	First		Middle Initial		Last				
Local & ID Card Mailing Address	Street or P.O.Box			City			State	Zip Code	
Permanent Address	Street or P.O.Box			City			State	Zip Code	
Email	*(A confirmation email will be sent upon enrollment)*			**Phone/Cell Number**		( ) —			
Male		**Female**		**Date of Birth**	(MM/DD/YYYY) / /	**SSN**	- -	**Student ID Number**	*(must be provided to be processed)*

NOTICE TO STUDENT. Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Student meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and **4)** Other than eligibility or entry into the Armed Forces, **the premium is not refundable**. It is the student's responsibility to make a timely renewal payment. This plan is underwritten by **Blue Cross and Blue Shield of Texas**.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

SIGNATURE: _____ DATE: _____

(Signature of Student, or Parent if Student is under age 18)

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side. **CONTINUE ON REVERSE SIDE →**

ahp Academic HealthPlans

187083-16 - Dental

University of Houston-Downtown 2016 - 2017
Fall Student Dental Insurance Enrollment Form

DOMESTIC AND INTERNATIONAL STUDENTS

Enrollment will NOT be accepted after the Open Enrollment Period
(see below for details)

Student Name: _____ Student ID Number: _____
(must be provided to be processed)

The student MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage. The student must enroll in the same plan and coverage period.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification: ☐ Domestic ☐ International

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE
Dental	**Annual*** 08/22/2016 through 08/21/2017	**Fall** 08/22/2016 through 01/16/2017	**Step 1** - Choose all desired premiums **Step 2** - Write the amount chosen in the applicable column(s) below **Step 3** - Calculate and submit total due
Open Enrollment Periods:	**from 07/18/2016 to 09/24/2016**	**from 07/18/2016 to 09/24/2016**	
Student	☐ $ 260.00	☐ $ 106.00	☐ $
		TOTAL	$

***Domestic Only**

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments. Please use the chart above to calculate total amount due.

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received**. If you have questions, please call Academic HealthPlans at **(855) 824-9683.**

PAYMENT OPTIONS									
If paying by credit card fax to **(817) 809-4701**								By check	
Name as it appears on the card								Make check or money order in U.S dollars, payable to	Academic HealthPlans
Billing Address								Check Amount	$
Amount to be charged		$						Check Number	
Credit Card Number								Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
VISA	☐	Master Card	☐	Discover	☐	Expiration Date	(MM/YY) /		

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. I understand my insurance will be cancelled if my credit card is declined. All charges will show on my credit card statement as Academic HealthPlans, Inc.**

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____