

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	<input type="checkbox"/>	Female	<input type="checkbox"/>	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 →

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)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Early arrival in the Spring **OR** Early arrival in the Summer

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE	
Medical	Spring/Summer 12/01/2016 through 12/31/2016	Summer 05/01/2017 through 05/31/2017	Step 1 - Choose only one of the early premiums Step 2 - Complete payment information below	
	Open Enrollment Periods: from 12/01/2016 to 12/15/2017	from 05/01/2017 to 05/15/2017		
Student	\$ 156.00	\$ 156.00	\$156.00	
TOTAL			\$156.00	

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: _____

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)

Early arrival in the Spring **OR** Early arrival in the Summer

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE	
Medical + Dental	Spring/Summer 12/01/2016 through 12/31/2016	Summer 05/01/2017 through 05/31/2017	Step 1 - Choose only one early premium Step 2 - Complete payment information below	
	Open Enrollment Periods: from 12/01/2016 to 12/15/2016	from 05/01/2017 to 05/15/2017		
Student	\$ 178.00	\$ 178.00	\$178.00	
TOTAL			\$178.00	

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.

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Billing Address				Check Amount	\$
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VISA	Master Card	Discover	Expiration Date (MM/YY) /		

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SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____