ahp | Academic HealthPlans℠

Mail Completed Form to:
Pacific University
Attn: Renee Vanzant
2043 College Way
Forest Grove, OR 97116

Fax:
Attn: Renee Vanzant
503-352-3030

Enrollment by Qualifying Event

This form must accompany the Academic Healthplans Enrollment Form

Student Name	First	Middle Initial	Last	**Social Security Number**	— —
School Name				**Policy Number**	

LIST DEPENDENTS TO BE INSURED BELOW

Dependent	First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security Number
Spouse				/ /		– –
Child 1				/ /		– –
Child 2				/ /		– –

QUALIFYING EVENT INFORMATION AND REQUIRED DOCUMENTATION

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and this completed form. **Application for enrollment must be submitted within 31 days of the qualifying event. Improper documentation will result in a return of premium and a delay of coverage.**

QUALIFYING EVENT DATE: _____/ _____/ _____

	QUALIFYING EVENT	DOCUMENTATION REQUIRED
	Please check the box below that is applicable to your situation. A box MUST be checked and the appropriate required documentation MUST accompany this form.	**Letter of Ineligibility (lost coverage) is required for any reason listed.**
☐	Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause) Cause of Loss: _____ _____	Written documentation from the school or insurance company, on school/company letterhead, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
☐	Acquired a new dependent — **spouse** (and adding other previously eligible dependents)	Copy of marriage certificate
☐	Acquired a new dependent — **newborn, adopted child, child arriving from another country** (and adding other previously eligible dependents)	Copy of birth certificate for newborn; or proper visa documentation for child(ren) arriving from another country

STUDENT SIGNATURE: _____ DATE: _____

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2016A4A12

Pacific University 2016 - 2017
Qualifying Event Enrollment Form
STUDENT DEPENDENTS

(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)*		

LIST DEPENDENTS TO BE INSURED BELOW. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

DEPENDENT INFORMATION						
Dependent	**First Name**	**MI**	**Last Name**	**Date of Birth** (MM/DD/YYYY)	**Gender** (M/F)	**Social Security Number**
Spouse				/ /		– –
Child 1				/ /		– –
Child 2				/ /		– –

NOTICE TO STUDENT AND CARDHOLDER. Coverage will be effective the date of the Qualifying Event if required documentation and form are received within 31 days of Qualifying Event, 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 **National Guardian Life Insurance Company**.

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 OF CARDHOLDER: _____ DATE: _____

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

PRINTED NAME OF CARDHOLDER: _____ DATE: _____

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

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2016A4A12

Pacific University 2016 - 2017
Qualifying Event Enrollment Form
STUDENT DEPENDENTS

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

CLASSIFICATION							
	☐	Physician Assistant (1, 2 or 3) 05/02/2016 through 05/05/2017	☐	Masters of Arts in Teaching 5th Year FG, WDB (New Starts) 06/20/2016 through 06/19/2017	☐	Master of Business Administration (Graduating) 08/12/2016 through 12/31/2016	☐	Master of Fine Arts (Traditional, SpEd, APT or Flex - Spring) 01/12/2017 through 08/12/2017
	☐	Physician Assistant (Graduating) 05/02/2016 through 08/31/2016	☐	Pharmacy 1, 2 and 3 08/01/2016 through 07/31/2017	☐	Master of Fine Arts (Spring Start) 01/01/2017 through 05/31/2017		
	☐	Master of Fine Arts (Fall Start) 06/01/2016 through 05/31/2017	☐	Domestic & International - All Other Programs, Annual 08/12/2016 through 08/11/2017	☐	Domestic & International - All Other Programs, Spring 01/01/2017 through 08/12/2017		

The monthly rate is to be used in the calculation of your total premium due **only** if the Covered Person has a qualifying event, such as marriage, birth, loss of coverage due to age limitation, etc. The monthly rate would be paid beginning in the month which the qualifying event occurred through the end of the current coverage period.

Note: *If this enrollment is for a dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the student's existing coverage.*

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES		MONTHLY RATE		CALCULATE GAP RATE
REQUESTED COVERAGE	___/___/_____ through ___/___/_____	Coverage	Monthly Rate	Example: $198 x 3 months = $594
		Student (Tuition billed)	$ 198.00	$ _____ (Rate) X _____ (# Periods) = $ _____ (Total)
		Spouse	$ 198.00	$ _____ (Rate) X _____ (# Periods) = $ _____ (Total)
		Children	$ 198.00	$ _____ (Rate) X _____ (# Periods) = $ _____ (Total)
			Processing Fee	$ 15.00
			TOTAL	$
Coverage may not extend past the termination date of your program's policy year.				

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 (details are provided below). Your 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) 856-2383**.

PAYMENT

Provide credit card information below									
Name as it appears on the card								Mail or fax completed enrolment form to	Mail: Pacific University Attn: Renee Vanzant 2043 College Way Forest Grove, OR 97116 Fax: Attn: Renee Vanzant 503-352-3030
Billing Address									
Amount to be charged	$								
Credit Card Number									
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: _____