ahp | Academic HealthPlans

101227-16 - Medical | 101228-16 - Dental

Southern Methodist University 2016 - 2017 Spring Student Health Insurance Plan

DOMESTIC AND INTERNATIONAL DEPENDENT MEDICAL AND/OR DENTAL ENROLLMENT FORM

Including students enrolling in dental only coverage for themselves and their dependents

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)*	

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must take place at the time of student enrollment, with the exception of newborn or adopted children or a qualifying event. 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				/ /		– –
Child 3				/ /		– –

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 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 →**

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101227-16 - Medical

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

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

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification: ☐ Domestic ☐ International

If the student does not waive the insurance for the fall semester, the charges for the Student Only coverage will be automatically added to your tuition bill for the fall semester. If a student wants to enroll in this coverage, please go to **www.smu.edu/healthinsurance** for enrollment information. If you want to enroll your dependents, please complete this form and return to Academic HealthPlans. The premium for dependents only must accompany the enrollment form.

PERIOD RATES AND COVERAGE DATES		CALCULATE TOTAL PREMIUM DUE	
Medical	**Spring/Summer** 01/10/2017 through 08/12/2017	**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 11/01/2016 to 02/19/2017**	*Example: Spouse with one child will write:* *($1,304 + $1,304 = $2,608)*	
Student *(Tuition billed)*	$ 1,304.00		$
Spouse	$ 1,304.00		$
One Child	$ 1,304.00		$
Two Children	$ 2,608.00		$
Three or more Children[1]	$ 3,912.00		$
		TOTAL	$

[1] **Coverage for three (3) or more children is calculated at the child rate times three (3).**

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) 357-0242**.

PAYMENT OPTIONS									
If paying by credit card fax to **(855) 858-1964**								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 enrolment 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: _____

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101227-15 - Medical | 101228-15 - Dental

Southern Methodist University 2016 - 2017 Spring Student Health Insurance Plan

DOMESTIC AND INTERNATIONAL DEPENDENT MEDICAL AND DENTAL ENROLLMENT FORM

Including students enrolling in dental only coverage for themselves and their dependents

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

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

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

*Optional Adult Dental coverage is only available to the student and spouse. Children that are under the age of 19 have pediatric dental benefits under the medical plan. The rate shown for children is the Medical Only rate. If you are a student that has turned 19, you are eligible to purchase the Adult Dental Plan by completing a Student Only Dental Qualifying Event Enrollment Form, available online at **smu.myahpcare.com**.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)
Student/Insured Classification: ☐ Domestic ☐ International

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE	
Medical + Dental	**Spring/Summer** 01/10/2017 through 08/12/2017		**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 11/01/2016 to 02/20/2017**		*Example: Student with Spouse and one child will write: ($130 + $1,434 + $1,304 = $3,313)*	
Student *(Dental only)*		$ 130.00		
Spouse		$ 1,434.00		$
One Child *(Medical only)*		$ 1,304.00		$
Two Children *(Medical only)*		$ 2,608.00		$
Three or more Children[1] *(Medical only)*		$ 3,912.00		$
		TOTAL		$

[1] **Coverage for three (3) or more children is calculated at the child rate times three (3).**

Please use the chart above to calculate total amount due.

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If paying by credit card fax to **(855) 858-1964**								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 enrolment 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: _____