

## Enrollment by Qualifying Event

**This form must accompany the Academic Healthplans Enrollment Form**

<b>Student Name</b>	First _____ Middle Initial _____ Last _____	<b>Social Security Number</b>	— —
<b>School Name</b>		<b>Policy Number</b>	

**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				/ /		— —
Child 3				/ /		— —

**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
<p><b>Please check the box below that is applicable to your situation.</b> <b>A box MUST be checked and the appropriate required documentation MUST accompany this form.</b></p>	<p><b>Letter of Ineligibility (lost coverage) is required for any reason listed.</b></p>
<input type="checkbox"/> 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
<input type="checkbox"/> Acquired a new dependent — <b>spouse</b> (and adding other previously eligible dependents)	Copy of marriage certificate
<input type="checkbox"/> Acquired a new dependent — <b>newborn, adopted child, child arriving from another country</b> (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: \_\_\_\_\_

FOR USE BY ACADEMIC HEALTHPLANS ONLY:		
Date Received:	Date Approved/Denied and Reason:	Effective Date:
Eligibility Representative Signature:		Date Signed:



(PLEASE PRINT CLEARLY or TYPE)

STUDENT INFORMATION						
<b>Student Name</b>		First	Middle Initial	Last		
<b>Local &amp; ID Card Mailing Address</b>		Street or P.O.Box		City	State	Zip Code
<b>Permanent Address</b>		Street or P.O.Box		City	State	Zip Code
<b>Email</b>		(A confirmation email will be sent upon enrollment)			<b>Phone/Cell Number</b>	
					( ) -	
<b>Male</b>	<input type="checkbox"/>	<b>Female</b>	<input type="checkbox"/>	<b>Date of Birth</b>	(MM/DD/YYYY) / /	<b>SSN</b>
				-	-	<b>Student ID Number</b>
				(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				/ /		- -
Child 3				/ /		- -

**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.

**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 →**

Student Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_  
(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification:  Undergraduate  Non-Funded Graduate  BCTC Campus  OPT Students

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 MONTHLY RATE
SPRING/ SUMMER	01/01/2017 through 08/14/2017	Coverage	Monthly Rate	Example: \$181 x 3 months = \$543
		Student	\$ 181.00	\$ _____ X _____ = \$ _____ Rate # Months Total
		Spouse	\$ 181.00	\$ _____ X _____ = \$ _____ Rate # Months Total
		Child	\$ 181.00	\$ _____ X _____ = \$ _____ Rate # Months Total
REQUESTED COVERAGE	____/____/____ through 08/14/2017	Children	\$ 362.00	\$ _____ X _____ = \$ _____ Rate # Months Total
			<b>TOTAL</b>	\$ _____

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) 856-2385.

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: \_\_\_\_\_