ahp | Academic HealthPlans

115548-17

University Of Oklahoma - Norman 2017 - 2018
Fall Student Health Insurance Enrollment Form

DOMESTIC, INTERNATIONAL STUDENTS,
GRADUATE ASSISTANTS 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				**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 Oklahoma**.

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 next page. **CONTINUE ON NEXT PAGE →**

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GRADUATE ASSISTANTS 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)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification:

☐ Norman Campus
- ☐ Domestic
- ☐ *F1 International
- ☐ *J1 International
- ☐ Graduate Assistant

☐ Tulsa Campus
- ☐ Domestic
- ☐ *F1 International
- ☐ *J1 International
- ☐ Graduate Assistant

*International students only have fall coverage period option.

PERIOD RATES AND COVERAGE DATES						CALCULATE TOTAL PREMIUM DUE	
	Annual 08/19/2017 through 08/18/2018		OR	**Fall** 08/19/2017 through 01/15/2018		**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 08/18/2017 to 09/01/2017**			**from 08/18/2017 to 09/01/2017**		*Example: Student with Spouse and children will write: ($1,640 + $1,475 + $1,312 = $4,427)*	
Student		$ 1,640.00			$ 683.00		$
Spouse		$ 1,475.00			$ 615.00		$
All Children		$ 1,312.00			$ 547.00		$
						TOTAL	$

Your rate will be calculated by Academic HealthPlans based on the date you enter the plan. Charge will be applied to your student account.
Please submit this form to Academic HealthPlans, Inc. P.O. Box 1605 Colleyville, TX 76034 or fax to 1-855-858-1964 for processing.

Charges will be applied to your student account.

SIGNATURE OF STUDENT: _____ DATE: _____

PRINTED NAME OF STUDENT: _____ DATE: _____