ahp | Academic HealthPlans™

Send completed form, required documentation, and premium payment to:
Academic HealthPlans, Inc.
PO Box 1605
Colleyville, TX 76034-1605

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				/ /		– –
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 in which the qualifying event occurred. 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 Cause of Loss: ____Maturing off the Pediatric Dental Coverage____	Must be enrolled in the Student Health Insurance Plan to qualify.

SIGNATURE: _____ DATE: _____

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097338-17 - Dental

University of Illinois-Springfield University 2017 - 2018 Dental Spring and Summer Qualifying Event Enrollment Form

STUDENTS

STUDENT TURNING AGE 19 AND ENROLLING IN OPTIONAL ADULT DENTAL ONLY COVERAGE

The student MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage.

(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)*

NOTICE TO STUDENT. Coverage will be effective the date **of the Qualifying Event if required documentation and form are received within 31 days in which the Qualifying Event occurred,** 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 Illinois**.

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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97338-17 - Dental

STUDENTS

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Student Name: _____ Student ID Number: _____

(must be provided to be processed)

(Please Check all appropriate boxes)

Student/Insured Classification: ☐ Domestic ☐ International

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

PERIOD RATES AND COVERAGE DATES

DENTAL COVERAGE DATES	
SPRING	01/10/2018 through 05/31/2018
OR	
SUMMER	06/01/2018 through 08/15/2018
QUALIFYING EVENT DATE	____/____/_____ through ____/____/_____
Coverage may not extend past the termination date shown above	

MONTHLY RATE		CALCULATE MONTHLY RATE
Coverage	Monthly Rate	Example: Student x $16 x 3 months = $48
Student	$ 16.00	$ ____16____ (Rate) X _____ (# Months) = $ _____ (Total)
TOTAL		$

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 **1-855-856-3549**.

PAYMENT OPTIONS

If paying by credit card fax to **1-855-858-1964**				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 enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
Expiration Date	(MM/YY) /				
VISA ☐	MasterCard ☐	Discover ☐			

☐ **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: _____