ahp | Academic HealthPlans™

101468-17 - Medical | 106145-17 - Dental

University of Texas at Arlington 2017 - 2018
Fall Student Health Insurance Enrollment Form

INTERNATIONAL STUDENT 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**	- -	**UT EID 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				/ /		– –

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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(see dates below)

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

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE	
Medical	**Fall** 08/15/2017 through 12/31/2017		**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 06/01/2017 to 10/01/2017**		*Example: Spouse and Children will write:* *($890 + $1,527 = $2,417)*	
Student (Tuition billed)	$ 890.00			
Spouse	$ 890.00		$	
Children	$ 1,527.00		$	
		TOTAL	$	

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 **1-855-247-7587**.

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: _____

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(see dates below)

Student Name: _____ UT EID 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 **uta.myahpcare.com**.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE	
Medical + Dental	**Fall** 08/15/2017 through 12/31/2017		**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 06/01/2017 to 10/01/2017**		*Example: Student with a Spouse and Children will write: ($100 + $990 + $1,527 = $2,617)*	
Student (Dental Only)	$	100.00	$	
Spouse	$	990.00	$	
***Children** (Medical Only)	$	1,527.00	$	
		TOTAL	$	

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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 ☐			

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SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____