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 (does not include loss due to failure to pay premiums or termination of coverage for cause)<br>Cause of Loss: _____<br>_____ | Written documentation from the insurance company, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility |
| ☐ | Acquired a new dependent — **spouse** (and adding other previously eligible dependents) | Copy of marriage certificate |
| ☐ | Acquired a new dependent — **newborn, adopted child, child arriving from another country** (and adding other previously eligible dependents) | Copy of birth certificate/birth record for newborn; or proper visa documentation for child(ren) arriving from another country |

STUDENT SIGNATURE: _____ DATE: _____

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165429-17 - Medical | 165430-17 - Dental

# Midwestern State University 2017 - 2018
# Spring/Summer Qualifying Event Enrollment Form

DOMESTIC STUDENTS AND THEIR DEPENDENTS

(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 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 **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 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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165429-17 - Medical

# Midwestern State University 2017 - 2018
# Spring/Summer Qualifying Event Enrollment Form

DOMESTIC STUDENTS AND THEIR DEPENDENTS

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

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**

| MEDICAL COVERAGE DATES | MONTHLY RATE | | *CALCULATE TOTAL PREMIUM |
|---|---|---|---|
| | Coverage | Monthly Rate | Example: $164 x 3 months = $492 |
| Qualifying Event Date<br>_____ / _____ / _____<br>through<br>07/31/2018 | Student | $ 164.00 | $164 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Spouse | $ 164.00 | $164 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Child | $ 164.00 | $164 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Two or More Children[1] | $ 328.00 | $328 (Rate) X _____ (# Months) = $ _____ (Total) |
| | | TOTAL | $ |
| | *TOTAL PREMIUM MUST BE PAID IN FULL | | |

[1] **Coverage for two (2) or more children is calculated at the child rate times two (2).**

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 **1-855-856-2386**.

**RENEWAL INFORMATION:** You must take affirmative steps to enroll and pay for any spouse/dependent each semester if you want coverage for them. There will be no renewal notice sent at the end of the coverage period.

**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<br>P.O. Box 1605<br>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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165429-17 - Medical | 165430-17 - Dental

# Midwestern State University 2017 - 2018
# Spring/Summer Qualifying Event Enrollment Form

DOMESTIC STUDENTS AND THEIR DEPENDENTS

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 **mwsu.myahpcare.com**.

(PLEASE CHECK ALL THE APPROPRIATE BOXES

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**

| MEDICAL + DENTAL COVERAGE DATES | MONTHLY RATE | | *CALCULATE TOTAL PREMIUM |
|---|---|---|---|
| | Coverage | Monthly Rate | Example: $184 x 3 months = $552 |
| **Qualifying Event Date** _____ / _____ / _____ **through 07/31/2018** | **Student** | $ 184.00 | $184 (Rate) X _____ (# Months) = $ _____ (Total) |
| | **Spouse** | $ 184.00 | $184 (Rate) X _____ (# Months) = $ _____ (Total) |
| | ***Child** *(Medical Only)* | $ 164.00 | $164 (Rate) X _____ (# Months) = $ _____ (Total) |
| | ***Two or More Children**[1] *(Medical only)* | $ 328.00 | $328 (Rate) X _____ (# Months) = $ _____ (Total) |
| | | **TOTAL** | $ |
| | ***TOTAL PREMIUM MUST BE PAID IN FULL** | | |

[1] **Coverage for two (2) or more children is calculated at the child rate times two (2).**

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 **1-855-856-2386**.

**RENEWAL INFORMATION:** You must take affirmative steps to enroll and pay for any spouse/dependent each semester if you want coverage for them. There will be no renewal notice sent at the end of the coverage period.

**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<br>P.O. Box 1605<br>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: _____