ahp | Academic HealthPlans™

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

Adult Dental Qualifying Event Enrollment Form

For Students Only who are aging off the Pediatric Dental that is included in the Medical Plan

This form must accompany the Academic Healthplans Enrollment Form

Student Name	First	Middle Initial	Last	**Social Security Number**	— —
School Name				**Policy Number**	

QUALIFYING EVENT INFORMATION AND REQUIRED DOCUMENTATION

Identify the qualifying event which caused the loss of other medical coverage for you. 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.**
☐	Maturing of the pediatric dental coverave	Must be enrolled in the SHIP to qualify.

STUDENT SIGNATURE: _____ DATE: _____

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101228-17 - Dental

Southern Methodist University System 2017 - 2018
Fall Adult Dental Qualifying Event Enrollment Form

DOMESTIC AND INTERNATIONAL STUDENTS ONLY WHO ARE AGING OFF THE PEDIATRIC DENTAL THAT IS INCLUDED IN THE MEDICAL PLAN

If you want to enroll yourself and/or your dependents in the adult dental coverage for any other eligible reason except aging off the pedicatric dental benefit that is included in the medical plan, please do not complete this form for yourself and/or your dependents. Please complete the regular Qualifying Event Enrollment Form.

(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 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. 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 →**

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Academic HealthPlans, Inc. (AHP) is a separate company that provides program management and administrative services for the student health plans of Blue Cross and Blue Shield of Texas.

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101228-17 - Dental

Southern Methodist University System 2017 - 2018
Fall Adult Dental Qualifying Event Enrollment Form

DOMESTIC AND INTERNATIONAL STUDENTS ONLY WHO ARE AGING OFF THE PEDIATRIC DENTAL THAT IS INCLUDED IN THE MEDICAL PLAN

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

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

(PLEASE CHECK ALL THE 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 qualifying event, such as 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.

PERIOD RATES AND COVERAGE DATES			
COVERAGE DATES	**DENTAL MONTHLY RATE**		**CALCULATE MONTHLY RATE**
Qualifying Event Date ____ /____/_____ **through** **12/31/17**	**Coverage**	**MONTHLY**	**Example: $20 x 3 months = $60**
	Student	$ 20.00	$20.00 X _____ (# Months) = $ _____ (Total)
Coverage may notextend past the termination date of 12/31/17	**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 **1-855-357-0242.**

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 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: _____