ahp | Academic HealthPlans℠

686176-19

Angelo State University 2019 - 2020
Fall Student Health Insurance Enrollment Form

VOLUNTARY/DOMESTIC STUDENTS AND THEIR DEPENDENTS

Enrollment will NOT be accepted after the Open Enrollment Period
(see next page 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**	- -	**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				/ /		– –

ENROLLMENT TERMS & CONDITIONS: 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 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 **Aetna Life Insurance Company**.

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 →**

ahp | Academic HealthPlans

686176-19

Angelo State University 2019 - 2020
Fall Student Health Insurance Enrollment Form

VOLUNTARY/DOMESTIC STUDENTS 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: ☐ Domestic ☐ Health Professionals

PERIOD RATES AND COVERAGE DATES					CALCULATE TOTAL PREMIUM DUE
	Annual 08/15/2019 through 08/14/2020	OR	**Fall** 08/15/2019 through 01/14/2020		**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:	**07/02/2019 through 10/01/2019**		**07/02/2019 through 10/01/2019**		*Example: Student with a Spouse and one child will write: ($2,990 + $2,990 + $2,990 + $15 = $8,985)*
Student	$ 2,990.00		$ 1,250.00		$
Spouse	$ 2,990.00		$ 1,250.00		$
One Child	$ 2,990.00		$ 1,250.00		$
Two or more Children[1]	$ 5,980.00		$ 2,500.00		$
				Processing Fee	$15.00
				TOTAL	$

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

The final cost will include a $15 processing fee. 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). **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 **1-855-850-4299.**

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	
Amount to be charged	$	Make check or money order in U.S. dollars, payable to	Academic HealthPlans
Credit Card Number		Check Amount	$
Expiration Date	(MM/YY) /	Check Number	
Billing Zip Code		Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐			

☐ **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. Any dependents enrolled in the Medical Insurance Plan must be eligible for coverage. The carrier may audit dependents to verify their eligibility. If your dependent(s) is(are) selected for audit, the carrier will email you with instructions to submit the documents needed to verify your dependent(s) eligibility. By signing and submitting this document you confirm that you have read the eligibility requirements for dependents, that your dependent(s) is(are) eligible for coverage, and that you will submit documentation required to verify your dependent(s) eligibility if audited by the carrier.**

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____