

238167-19 Medical | 238168-19 Dental

RETURNING STUDENT 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				/ /		- -

**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 next page. **CONTINUE ON NEXT PAGE →**

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(see dates below)

Student Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

COVERAGE AND ENROLLMENT DATES		CALCULATE TOTAL PREMIUM DUE				
<b>Medical Includes Dental</b>	Annual 07/01/2019 through 06/30/2020	Please indicate which members you are enrolling by using the check boxes below	1 <sup>st</sup> Charge	2 <sup>nd</sup> Charge	3 <sup>rd</sup> Charge	4 <sup>th</sup> Charge
	Open Enrollment Periods: from 05/07/2019 through 05/28/2019		Charged upon receipt	Charged 9/16/19	Charged 12/16/19	Charged 3/16/20
*I understand my payments will be charged in 4 parts. I authorize AHP to charge on the dates listed to the right		<input type="checkbox"/> Spouse	\$ 1,399.50	\$ 1,399.50	\$ 1,399.50	\$ 1,399.50
		<input type="checkbox"/> Child <sup>2</sup>	\$ 1,338.75	\$ 1,338.75	\$ 1,338.75	\$ 1,338.75
		<input type="checkbox"/> Two or More Children <sup>1,2</sup>	\$ 2,677.50	\$ 2,677.50	\$ 2,677.50	\$ 2,677.50
		<b>TOTAL</b> To be charged on the dates listed above	\$	\$	\$	\$

<sup>1</sup>Coverage for two (2) or more children is calculated at the child rate times two (2).

<sup>2</sup>Coverage includes Pediatric Dental only.

Please use chart above to calculate total due.

**PAYMENT INFORMATION.** You can pay via credit card (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 1-855-856-4117.

**RENEWAL INFORMATION:** You must take affirmative steps to enroll and pay for any spouse/dependent each year 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	
*Amount to be charged	\$
Credit Card Number	
Expiration Date	(MM/YY) /
Billing Zip Code	
VISA <input type="checkbox"/>	MasterCard <input type="checkbox"/>
Discover <input type="checkbox"/>	AMEX <input type="checkbox"/>

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.

Please mail completed form to Academic HealthPlans: P.O. Box 1605 Colleyville, TX 76034. You may also fax to 1-855-858-1964.

SIGNATURE OF STUDENT: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME OF STUDENT: \_\_\_\_\_ DATE: \_\_\_\_\_