ahp | Academic HealthPlans

25-85558-19
Effective Date of Policy: 08/01/2019

# Clemson University 2019 - 2020
# Annual/Fall Student Health Insurance Enrollment Form

## VOLUNTARY 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** *(required for **Domestic Students** to activate coverage)* - - | | **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 **Blue Cross and Blue Shield of South Carolina**.

**I understand my information is protected by privacy laws and will be released only in accordance with these laws.**

**My signature below represents 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 OF CARDHOLDER: _____ DATE: _____

(Signature of Student, or Parent/Guardian 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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**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: ☐ Voluntary ☐ ClemsonLIFE Program

| PERIOD RATES AND COVERAGE DATES | | | | | | CALCULATE TOTAL PREMIUM DUE | |
|---|---|---|---|---|---|---|---|
| | **Annual** 08/01/2019 through 07/31/2020 | | OR | **Fall** 08/01/2019 through 12/31/2019 | | **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 07/24/2019 through 09/02/2019** | | | **from 07/24/2018 through 09/02/2019** | | *Example: A Student, Spouse and one child will write: ($2,981.55 + $2,981.55 + $2,981.55 = $8,944.65)* | |
| **Student** | | $ 2,981.55 | | | $ 1,257.42 | | $ |
| **Spouse** | | $ 2,981.55 | | | $ 1,257.42 | | $ |
| **Each Child** | | $ 2,981.55 | | | $ 1,257.42 | | $ |
| **Three or More Children** | | $ 8,944.65 | | | $ 3,772.26 | | $ |
| | | | | | | **TOTAL** | $ |

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments. 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 **1-855-856-2384**.

**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<br>P.O. Box 1605<br>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 premium. I understand the insurance will be cancelled if the 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: _____