



25-85558-18 Effective Date of Coverage: 08/01/2018



VOLUNTARY STUDENTS AND THEIR DEPENDENTS

Enrollment will NOT be accepted after the Open Enrollment Period (see reverse side for details)

(PLEASE PRINT CLEARLY or TYPE)

STUDENT INFORMATION form with fields for Student Name, Local & ID Card Mailing Address, Permanent Address, Email, Phone/Cell Number, Date of Birth, SSN, and Student ID Number.

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 INFORMATION table with columns for Dependent, First Name, MI, Last Name, Date of Birth, Gender, and Social Security Number.

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.

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.

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 ->



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

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

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification:  Voluntary  ClemsonLIFE Program

Table with 2 main columns: PERIOD RATES AND COVERAGE DATES and CALCULATE TOTAL PREMIUM DUE. It includes rows for Open Enrollment Periods, Student, Spouse, Each Child, Three or More Children, and a TOTAL row.

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.

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 table with columns for credit card payment (VISA, MasterCard, Discover, AMEX) and check payment details.

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.

SIGNATURE OF CARDHOLDER: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME OF CARDHOLDER: \_\_\_\_\_ DATE: \_\_\_\_\_