

Enrollment by Qualifying Event

This form must accompany the Academic Healthplans Enrollment Form

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

LIST DEPENDENTS TO BE INSURED BELOW

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				/ /		— —

QUALIFYING EVENT INFORMATION AND REQUIRED DOCUMENTATION

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. 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 delay of coverage.**

QUALIFYING EVENT DATE: ____/____/____

QUALIFYING EVENT	DOCUMENTATION REQUIRED
<p>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.</p>	<p>Letter of Ineligibility (lost coverage) is required for any reason listed.</p>
<input type="checkbox"/> Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause) Cause of Loss: _____ _____	Written documentation from insurance company, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
<input type="checkbox"/> Acquired a new dependent — spouse (and adding other previously eligible dependents)	Copy of marriage certificate
<input type="checkbox"/> Acquired a new dependent — newborn, adopted child, child arriving from another country (and adding other previously eligible dependents)	Copy of birth certificate/birth record for newborn; or proper visa documentation for child(ren) arriving from another country

STUDENT SIGNATURE: _____ DATE: _____

115548-18

DOMESTIC, INTERNATIONAL STUDENTS,
GRADUATE ASSISTANTS AND THEIR DEPENDENTS



(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					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 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 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 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 Oklahoma.

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 →**

Student Name: _____

Student ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

- Student/Insured Classification:
- | | |
|---|---|
| <input type="checkbox"/> Norman Campus | <input type="checkbox"/> Tulsa Campus |
| <input type="checkbox"/> Domestic | <input type="checkbox"/> Domestic |
| <input type="checkbox"/> F1 International | <input type="checkbox"/> F1 International |
| <input type="checkbox"/> J1 International | <input type="checkbox"/> J1 International |
| <input type="checkbox"/> Graduate Assistant | <input type="checkbox"/> Graduate Assistant |

Note: If this enrollment is for a dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the student's existing coverage.

MONTHLY RATES AND COVERAGE DATES				
		Annual 08/19/2018 through 08/18/2019		Fall 08/19/2018 through 01/13/2019
Student		\$ 144.33	OR	\$ 144.33
Spouse		\$ 129.83		\$ 129.83
All Children		\$ 109.34		\$ 115.50

Your rate will be calculated by Academic HealthPlans based on the date you enter the plan. Charge will be applied to your student account. Please submit this form to Academic HealthPlans, Inc. P.O. Box 1605 Colleyville, TX 76034 or fax to 1-855-858-1964 for processing.

SIGNATURE OF STUDENT: _____ DATE: _____

PRINTED NAME OF STUDENT: _____ DATE: _____