ahp | Academic HealthPlans

Send completed form, required documentation, and premium payment to:
Academic HealthPlans, Inc.
PO Box 1605
Colleyville, TX 76034-1605
Or Fax to: 1-855-858-1964

Enrollment or Drop by Qualifying Event

This form must accompany the Academic HealthPlans Enrollment Form if adding coverage

Please select a box: ☐ Adding GS or dependent coverage ☐ Dropping GS or dependent coverage

Graduate Staff Name	First	Middle Initial	Last	Social Security Number	— —
School Name					

LIST DEPENDENTS TO BE INSURED OR DROPPED BELOW

Dependent	First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security Number (if applicable)
Graduate Staff				/ /		— —
Spouse				/ /		— —
Child 1				/ /		— —
Child 2				/ /		— —
Child 3				/ /		— —

QUALIFYING EVENT INFORMATION AND REQUIRED DOCUMENTATION

Identify the qualifying event which caused the loss or addition of other medical coverage for your eligible dependents. You must submit the appropriate required documentation, proof of prior or current coverage, and this completed form. **Application for enrollment or disenrollment must be submitted within 31 days in which the qualifying event occurred. Improper documentation will result in a delay of addition or drop of coverage.**

QUALIFYING EVENT DATE: _____/ _____/ _____

	QUALIFYING EVENT TO ADD	DOCUMENTATION REQUIRED
	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 to add.**	**Proper documentation is required for any reason listed.**
☐	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 the insurance company providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
☐	Acquired a new dependent — **spouse by marriage or arriving from another country** (and adding other previously eligible dependents)	Copy of marriage certificate and/or travel documentation required
☐	Acquired a new dependent — **newborn, adopted child, child arriving from another country** (and adding other previously eligible dependents)	Copy of birth certificate for newborn or proof of birth; or proper visa documentation for child(ren) arriving from another country

	QUALIFYING EVENT TO DROP	DOCUMENTATION REQUIRED
	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 to drop.**	**Proper documentation is required for any reason listed.**
☐	Acquired eligibility of another plan: Cause of acquisition: _____	Proof of other coverage: Should include coverage effective date and the name should match the name listed above.
☐	Loss of a dependent - Divorce, Annulment, Death.	Legal documentation required.
☐	Loss of a dependent - Leaving the US.	Travel documentation required.

****If you are dropping your medical insurance plan, there is no need to fill out the subsequent pages.** A credit of the premium paid, for coverage after the termination date will be made to your bank account or to the card on file. Coverage will be terminated as of the last day of the month in which the Qualifying Event occurred.

GRADUATE STAFF SIGNATURE: _____ DATE: _____

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IN2008M001-19

Purdue University 2019 - 2020 Qualifying Event Enrollment Form

GRADUATE STAFF AND DEPENDENTS

(PLEASE PRINT CLEARLY or TYPE)

GRADUATE STAFF INFORMATION											
Graduate Staff 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**	- -	**Purdue ID Number**	*(must be provided to be processed)*		

LIST DEPENDENTS TO BE INSURED BELOW. Dependent coverage is available only if the Graduate Staff is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the Graduate Staff.

DEPENDENT INFORMATION						
Dependent	**First Name**	**MI**	**Last Name**	**Date of Birth** (MM/DD/YYYY)	**Gender** (M/F)	**Social Security Number**
Graduate Staff				/ /		– –
Spouse				/ /		– –
Child 1				/ /		– –
Child 2				/ /		– –
Child 3				/ /		– –

ENROLLMENT TERMS & CONDITIONS: 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.** This plan is underwritten by **Anthem Blue Cross Blue Shield**.

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 OF GRADUATE STAFF: _____ DATE: _____

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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IN2008M001-19

Purdue University 2019 - 2020 Qualifying Event Enrollment Form

GRADUATE STAFF AND DEPENDENTS

Graduate Staff Name: _____ Graduate Staff ID Number: _____

(must be provided to be processed)

(PLEASE CHECK THE APPROPRIATE BOX)

The monthly rate is to be used in the calculation of your total premium due **only** if the Covered Person has a qualifying event, such as marriage, birth, loss of coverage due to age limitation, etc. The monthly rate would be paid beginning in the month which the qualifying event occurred through the end of the current coverage period.

Note: *The dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the Graduate Staff's employment or the policy end date of 07/31/2020.*

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES	*MONTHLY RATE		**CALCULATE TOTAL PREMIUM DUE
	Coverage	Monthly Rate	
Qualifying Event Date _____ /_____/_____ through 07/31/2020 or the End of Graduate Staff Employment	Graduate Staff	$ 47.67	
	Spouse	$ 210.75	The Qualifying Event Date determines the amount charged initially. We will reach out to you with the total premium amount and payment schedule.
	Each Child	$ 210.75	
	All Children	$ 421.58	
		TOTAL	$
			**TOTAL PREMIUM MUST BE PAID IN FULL
No charge for the 1st month for Newborns	*May include applicable fees based on Graduate Staff's selected payment method.		

PAYMENT INFORMATION. Method of payment will default to Graduate Staff's chosen payment method at time of registration. **It is the Graduate Staff's responsibility for timely renewal of dependent coverage whether or not a renewal notice is received**. If you have questions, please call Academic HealthPlans at **1-855-566-7278**.

PAYMENT OPTIONS

Premiums will be charged to the Payment Method that was selected during the initial enrollment process.

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate the payment of dependents premium. I understand the insurance will be cancelled if payment is not made. All charges will show as Academic HealthPlans, Inc.**

SIGNATURE OF GRADUATE STAFF: _____ DATE: _____

PRINTED NAME OF GRADUATE STAFF: _____ DATE: _____