ahp Academic HealthPlans

125284-19

Rosalind Franklin University 2019 - 2020 Student Health Insurance Enrollment Form

DOMESTIC AND INTERNATIONAL DEPENDENTS (NEW INCOMING STUDENTS)

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				/ /		– –

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 Illinois**.

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 →**

ahp Academic HealthPlans

125284-19

Rosalind Franklin University 2019 - 2020 Student Health Insurance Enrollment Form

DOMESTIC AND INTERNATIONAL DEPENDENTS (NEW INCOMING STUDENTS)

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)

College: ☐ Domestic ☐ International

COVERAGE AND ENROLLMENT DATES		CALCULATE TOTAL PREMIUM DUE			
	Annual 08/01/2019 through 06/30/2020	Please indicate which members you are enrolling by using the check boxes below	Fall 1st Charge	Winter 2nd Charge	Spring 3rd Charge
Open Enrollment Periods:	**from 06/25/2019 through 08/23/2019**		Charged upon receipt	Charged 10/15/19	Charged 2/14/20
***I understand my payments will be charged in 3 parts. I authorize AHP to charge on the dates listed to the right**		☐ **Spouse**	$ 838.02	$ 1,117.36	$ 1,117.36
		☐ **Child**	$ 838.02	$ 1,117.36	$ 1,117.36
		☐ **Two or More Children**	$ 1,676.04	$ 2,234.72	$ 2,234.72
		TOTAL To be charged on the dates listed above	$	$	$

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 ☐	MasterCard ☐	Discover ☐	AMEX ☐

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium requested and on dates specified above. 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: _____