

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 return of premium and 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 the 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: _____

(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				/ /		- -

NOTICE TO STUDENT AND CARDHOLDER. 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 and cardholder 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 **Delta Dental.**

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 reverse side. **CONTINUE ON REVERSE SIDE →**

Student Name: _____

Student ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

- Student/ Campuses: Texas A&M University Texas A&M International University Texas A&M University - Central Texas
 Texas A&M University - Commerce Texas A&M University - Corpus Christi Texas A&M University - Galveston
 Texas A&M University - Kingsville Texas A&M University - Texarkana Texas A&M University - San Antonio
 Prairie View A&M University Tarleton State University West Texas A&M University

PERIOD RATES AND COVERAGE DATES			
DENTAL RATE		*CALCULATE TOTAL PREMIUM	
Coverage	Spring Qualifying Event Date ____/____/____ through 08/31/2018		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
Student	\$	240.00	
Spouse	\$	240.00	
All Children	\$	480.00	
		TOTAL	\$
*TOTAL PREMIUM TO BE PAID IN FULL			

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 **1-877-624-7911**.

PAYMENT OPTIONS			
If paying by credit card fax to 1-855-858-1964		By check	
Name as it appears on the card		Make check or money order in U.S dollars, payable to	Academic HealthPlans
Billing Address		Check Amount	\$
Amount to be charged	\$	Check Number	
Credit Card Number		Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
Expiration Date	(MM/YY) /		
VISA <input type="checkbox"/>	MasterCard <input type="checkbox"/>	Discover <input type="checkbox"/>	

By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. 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.

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____