ahp | Academic HealthPlans™

Send completed form, required documentation, and premium payment to:
Academic HealthPlans
P.O. Box 1605
Colleyville, TX 76034

Enrollment by Qualifying Event

This form must accompany the Academic HealthPlans Enrollment Form

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

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 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 30 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
	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.	**Letter of Ineligibility (lost coverage) 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, on company letterhead, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
☐	Acquired a new dependent — **spouse** (and adding other previously eligible dependents)	Copy of marriage certificate
☐	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: _____

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University of Houston-Main Campus 2019 - 2020 Student Health Insurance Request Form

2019-202521-1

DEPENDENT ONLY PLAN

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 within the same open enrollment period as the student's 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 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 **of the Qualifying Event if required documentation and form are received within 30 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 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 **UnitedHealthcare Insurance Company**.

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 →**

University of Houston-Main Campus 2019 - 2020 Student Health Insurance Request Form

2019-202521-1

DEPENDENT ONLY PLAN

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

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

Note: *The dependent is allowed to purchase only the coverage period that matches the student's existing coverage.*

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES			
Qualifying Event Date _____ /_____/_____ **through** _____ /_____/_____ **(End date must be the same as the student)** **No charge for the 1st month for Newborns**	The rate will be calculated based on the coverage period of the student. The student will be notified of total premium prior to enrollment.	Monthly Payment	
		Spouse	$ 818.00
		Child*	$ 818.00
	TOTAL	$ to be confirmed via email from AHP representative	

*Coverage for two (2) or more children is calculated at the child rate times two (2).

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments.

PAYMENT INFORMATION. You can pay via credit card or debit card (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 1-855-824-9683.**

RENEWAL INFORMATION: You must take affirmative steps to enroll and pay for yourself each semester if you want coverage. There will be no renewal notice sent at the end of the coverage period.

PAYMENT OPTIONS			
Payment for Dependents: Your 2019-2020 insurance premium will be calculated according to the coverage period of the student. An AHP Representative will reach out to you with the total and a payment plan. Please supply valid and legible email address.			
If paying by credit card fax to **1-855-858-1964**			
Amount to be charged	$ to be confirmed via email from AHP representative		
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. 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: _____