

(PLEASE PRINT CLEARLY or TYPE)

SCHOLAR'S INFORMATION									
Scholar's 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	- -	Scholar's ID Number	(must be provided to be processed)

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must take place at the time of scholar's enrollment, with the exception of newborn or adopted children or a qualifying event. Dependent coverage is available only if the scholar is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the scholar.

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 SCHOLAR. 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 scholar and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Scholar meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the scholar 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 scholar'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 Scholar 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 Scholar, or Parent if Scholar 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 NEXT PAGE →**

2018-203371-4

VISITING SCHOLARS/STUDENTS AND THEIR DEPENDENTS

Scholar Name: _____

Scholar ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES			
COVERAGE DATES	MONTHLY RATE		CALCULATE MONTHLY RATE
REQUESTED COVERAGE ____/____/____ through ____/____/____ Coverage may not extend past the termination date of 08/31/2019	Coverage	Monthly Rate	Example: \$183 x 3 months = \$549
	Scholar	\$ 183.00	$\frac{\$183}{\text{Rate}} \times \frac{\text{# Months}}{\text{# Months}} = \$ \frac{\text{Total}}{\text{Total}}$
	Spouse	\$ 183.00	$\frac{\$183}{\text{Rate}} \times \frac{\text{# Months}}{\text{# Months}} = \$ \frac{\text{Total}}{\text{Total}}$
	Child	\$ 183.00	$\frac{\$183}{\text{Rate}} \times \frac{\text{# Months}}{\text{# Months}} = \$ \frac{\text{Total}}{\text{Total}}$
	Two or More Children ¹	\$ 366.00	$\frac{\$366}{\text{Rate}} \times \frac{\text{# Months}}{\text{# Months}} = \$ \frac{\text{Total}}{\text{Total}}$
	TOTAL		\$ _____

¹Coverage 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. Please use the chart above to calculate total amount due.

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the scholar'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			
If paying by credit card fax to 1-855-858-1964		By check	
Amount to be charged	\$ _____	Make check or money order in U.S. dollars, payable to	Academic HealthPlans
Credit Card Number	_____	Check Amount	\$ _____
Expiration Date	(MM/YY) _____ / _____	Check Number	_____
Billing Zip Code	_____	Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1805
VISA <input type="checkbox"/>	MasterCard <input type="checkbox"/>	Discover <input type="checkbox"/>	AMEX <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: _____