ahp | Academic HealthPlans

University of Houston 2019 - 2020 Health Insurance Enrollment Form

2019-203371-1

VISITING SCHOLARS/STUDENTS AND THEIR DEPENDENTS

(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				/ /		– –

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 scholar 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 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 next page. **CONTINUE ON NEXT PAGE →**

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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
	Coverage	Monthly Rate	Example: $204 x 3 months = $612
REQUESTED COVERAGE ____/____/_____ through ____/____/_____	Scholar	$ 204.00	$204 (Rate) X _____ (# Months) = $ _____ (Total)
	Spouse	$ 204.00	$204 (Rate) X _____ (# Months) = $ _____ (Total)
	Child	$ 204.00	$204 (Rate) X _____ (# Months) = $ _____ (Total)
	Two or More Children[1]	$ 408.00	$408 (Rate) X _____ (# Months) = $ _____ (Total)
Coverage may not extend past the termination date of 08/31/2020		TOTAL	$

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

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 76034-1605
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: _____