ahp Academic HealthPlans℠

University of Houston-Main Campus 2019- 2020 Annual/Fall Student Health Insurance Enrollment Form

2019-202521-1

DOMESTIC 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)*

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 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 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 →**

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(see below for details)

Student Name: ______________________________ Student ID Number: ______________________________

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES									CALCULATE TOTAL PREMIUM DUE	
	Annual: Returning Students 09/01/2019 through 08/31/2020		OR	**Fall: New Students** 08/01/2019 through 12/31/2019		OR	**Fall: Returning Students** 09/01/2019 through 12/31/2019		**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	
Open Enrollment Periods:	**from 07/22/2019** through **09/20/2019**			**from 07/22/2019** through **09/20/2019**			**from 07/22/2019** through **09/20/2019**			
Student		$ 2,590.00			$ 1,085.00			$ 864.00		$
									TOTAL	$

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). **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			
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: ______________