

University of Illinois-Springfield 2019 - 2020 Fall Student Health Insurance Enrollment Form

97337-19 - Medical | 097338-19 - Dental

ESL DEPENDENTS

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

(PLEASE PRINT CLEARLY or TYPE)

(CENSET WITH SEED WILL STATE)												
STUDENT INFORMATION												
Student Name				First		Last						
Local & ID Card Mailing Address			dress	Street or P.O.Box		City		State	Zip Code			
Permanent Address				Street or P.O.Box		City	State	Zip Code				
Email (A confirmation email v			on email w	ll be sent upon enrolli	ment)			Phone/Cell Number	r	()	_	
Male		Female		Date of Birth	(MM/DD/YYYY) / /	SSN		Student ID (must be provided to be procedure) - Number				sed)

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		of Birth DD/YYYY)	Gender (M/F)	Social Se	curity 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 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 Blue Cross and Blue Shield of Illinois.

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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97337-19 - Medical

ESL DEPENDENTS

Enrollment will NOT be accepted after the Open Enrollment Period

(see dates below)

udent Name:						Student ID Number: (must be provided to be processed)			
se check all appropriate boxes)								
PERIOD	RATES AND COV	VERAGE D	ATES					CALCUL	ATE TOTAL PREMIUM DUE
Medical Fall 1 08/16/2019 through 01/09/2020				Fall 2 10/20/2019 through 01/09/2020			Step 1 - Choose all desired premiur Step 2 - Write the amount chosen in applicable column(s) below Step 3 - Calculate and submit total of		Write the amount chosen in the applicable column(s) below
Open Enrollment Periods:	from 08/01/2019 through 09/25/2019				om 08/0 ough 09/	1/2019 25/2019	Example: Spouse and one child will write: (\$881 + \$881 = \$1,762)		
Student (Tuition billed)	\$	881.00	OR		\$	492.00			
Spouse	\$	881.00			\$	492.00		\$	
Child	\$	881.00			\$	492.00		\$	
Two or More Children	\$	1,762.00			\$	984.00		\$	
						тот	AL	\$	
wal payment whether or not wal INFORMATION: You n	a renewal notice	is received ive steps t	l. If yo	u have	questio	ns, please call	Acad	demic Health	the student's responsibility for a plans at 1-855-856-3549. Emester if you want coverage for
wal payment whether or not wal INFORMATION: You n	a renewal notice	is received ive steps t	l. If yo o enro e perio	ou have oll and pod.	questio	ns, please call	Acad	demic Health	nPlans at 1-855-856-3549 .
wal payment whether or not wall payment whether or not will be no renewal notice ser	a renewal notice nust take affirmat nt at the end of th	is received tive steps to the coverage	e perio	u have	questio	ns, please call	Acad	demic Health dent each se	Plans at 1-855-856-3549 . Pemester if you want coverage for
wal payment whether or not wall INFORMATION: You not will be no renewal notice sen	a renewal notice	is received tive steps to the coverage	e perio	ou have oll and pod.	questio	ns, please call	Acad pender mo	demic Health dent each se E oney order	nPlans at 1-855-856-3549 .
wal payment whether or not wal INFORMATION: You not will be no renewal notice send and the send of the	nust take affirmat that the end of th it card fax to 1-85	is received tive steps to the coverage	e perio	ou have oll and pod.	questio	ns, please call any spouse/de DNS Make check o	pen r mc	demic Health dent each se E oney order	Plans at 1-855-856-3549 . Pemester if you want coverage for By check
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WAL INFORMATION: You n will be no renewal notice ser If paying by cred unt to be charged it Card Number	nust take affirmat that the end of the it card fax to 1-85	is received tive steps to the coverage	e perio	ou have oll and pod.	questio	ns, please call any spouse/de DNS Make check of in U.S. dollars Check Amour Check Numbe	r mc, pay	demic Health dent each se	Plans at 1-855-856-3549 . Pemester if you want coverage for By check Academic HealthPlans
wal payment whether or not EWAL INFORMATION: You not will be no renewal notice ser	nust take affirmat that the end of the it card fax to 1-85	is received rive steps t e coverage 55-858-196	e perio	ou have	questio	ns, please call any spouse/de DNS Make check of in U.S. dollars Check Amour Check Numbe	r mc, pay	demic Health dent each se	Plans at 1-855-856-3549. Emester if you want coverage for By check Academic HealthPlans \$ Academic HealthPlans
If paying by cred bunt to be charged lit Card Number ration Date MasterCard By signing this form, I hereby	a renewal notice nust take affirmat at the end of th it card fax to 1-85 \$ (MM/YY) Discover authorize Acade	is received ive steps the coverage is 55-858-196	PAA AME	u have pll and p pd. YMEN	question pay for FOPTIC	ns, please call any spouse/de DNS Make check of in U.S. dollars Check Amour Check Number Mail check an enrollment for redit card trar	Acadepen r mode, pay	demic Health dent each se	Academic HealthPlans P.O. Box 1605 Collegville, TX 76034-1605
If paying by cred bunt to be charged dit Card Number ration Date MasterCard By signing this form, I hereby	a renewal notice nust take affirmat at the end of the it card fax to 1-85 \$ (MM/YY) Discover authorize Acade d if my credit card	is received dive steps to the coverage steps	PAAAMEX	ou have pll and pod. YMEN to initial charge	questio pay for F OPTIO	ns, please call any spouse/de DNS Make check of in U.S. dollars Check Amour Check Number Mail check an enrollment for redit card transow on my crea	Acadepen r mode, pay	demic Health dent each se Beaney order vable to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605



University of Illinois-Springfield 2019 - 2020 Fall Student Health Insurance Enrollment Form

97337-19 - Medical | 097338-19 - Dental

ESL STUDENTS AND THEIR DEPENDENTS

	Enrollment will NOT be accepted after the Open Enrollment Period
	(see dates below)
Student Name:	Student ID Number:
	(must be provided to be processed)

The student and/or spouse MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage. The student and spouse must enroll in the same plan and coverage period.

*Optional Adult Dental coverage is only available to the student and spouse. Children that are under the age of 19 have pediatric dental benefits under the medical plan. The rate shown for children is the Medical Only rate. If you are a student that has turned 19, you are eligible to purchase the Adult Dental Plan by completing a Student Only Dental Qualifying Event Enrollment Form, available online at uis.myahpcare.com.

(Please check all appropriate boxes)

PRINTED NAME OF CARDHOLDER: __

PERIOD RA	TES AN		CALCULATE TOTAL PREMIUM DUE							
Medical + Dental	Fall 1 08/16/2019 through 01/09/2020			Fall 2 10/20/2019 through 01/09/2020				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 08/01/2019 through 09/25/2019		OR	from 08/01/2019 through 09/25/2019			Ex	ample: Student with a Spouse and one child will write: (\$82 + \$963 + \$881 = \$1,926)		
Student (Dental only)	\$ 82.00				\$	46.00		\$		
Spouse	5	963.00			\$	538.00		\$		
*Child (Medical only)	Ş	881.00			\$	492.00		\$		
*Two or More Children (Medical only)	ç	1,762.00	2.00		\$	984.00		\$		
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 1-855-856-3549.

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

	PAYMENT OPT	IONS			
If paying by credi	it 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	Academic HealthPlans P.O. Box 1605		
VISA MasterCard	Discover AMEX	enrollment form to	Colleyville, TX 76034-1605		
	authorize Academic HealthPlans to initiate a d if my credit card is declined. All charges will				
IGNATURE OF CARDHOLDER:		DATE:			

DATE: