ahp Academic HealthPlans℠

University of Louisville 2018-2019
Student Health Insurance Enrollment Form

2018-382-1

GA/RA/TA DEPENDENTS

(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 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.**

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare.

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 STUDENT. 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 eligibility or 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 reverse side. **CONTINUE ON NEXT PAGE →**

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Student Name: ______________________________ Student ID Number: ______________________
(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Must purchase by credit card, please choose the number of months you would like to purchase coverage for and input the dates below. Your credit card will be charged once per month for the number of months required to term 7/31/19.

☐ **I understand if I have dependents currently enrolled they will continue to be enrolled for the same coverage period I am requesting.**

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES	
ANNUAL	08/01/2018 through 07/31/2019
REQUESTED COVERAGE	____/____/______ through 07/31/2019
Coverage may not extend past the termination date of 07/31/2019	

MONTHLY RATE			CALCULATE MONTHLY RATE
Coverage	Monthly Rate		Example: $240 x 2 months = $480.00
Spouse		$ 240.00	$ 240 (Rate) X ____ (# Months) = $ ______ (Total)
Each Child		$ 240.00	$ 240 (Rate) X ____ (# Months) = $ ______ (Total)
All Children		$ 480.00	$ 480 (Rate) X ____ (# Months) = $ ______ (Total)
		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 **1-855-850-4191**.

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 now 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 ☐ 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: ______________