

Enrollment by Qualifying Event

This form must accompany the Academic Healthplans Enrollment Form

Student Name	First	Middle Initial	Last	Social Security Number	—	—
School Name						

QUALIFYING EVENT INFORMATION AND REQUIRED DOCUMENTATION

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and this completed form. **Application for enrollment must be submitted within 31 days in which the qualifying event occurred. Improper documentation will result in a return of premium and a delay of coverage.**

QUALIFYING EVENT DATE: ____/____/____

	QUALIFYING EVENT	DOCUMENTATION REQUIRED
	<p>Please check the box below that is applicable to your situation. A box MUST be checked and the appropriate required documentation MUST accompany this form.</p>	<p>Letter of Ineligibility (lost coverage) is required for any reason listed.</p>
<input type="checkbox"/>	Loss of eligibility Cause of Loss: <u> Maturing off the Pediatric Dental Coverage </u>	Must be enrolled in the Student Health Insurance Plan to qualify.

SIGNATURE: _____ DATE: _____



(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	- -	UT EID	(must be provided to be processed)

ENROLLMENT TERMS & CONDITIONS: Coverage will be effective the date of the Qualifying Event if required documentation and form are received within 31 days in which the Qualifying Event occurred, 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 Texas**.

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 →**

106145-19- Dental

STUDENT TURNING AGE 19 AND ENROLLING IN
OPTIONAL ADULT DENTAL COVERAGE

Student Name: _____

UT EID Number: _____
(must be provided to be processed)

The student MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

CAMPUS	<input type="checkbox"/>	UT Arlington	<input type="checkbox"/>	UT El Paso	<input type="checkbox"/>	UT MD Anderson	<input type="checkbox"/>	UT Rio Grande Valley School of Medicine
	<input type="checkbox"/>	UT Austin	<input type="checkbox"/>	UT HSC Houston	<input type="checkbox"/>	UT MB Galveston	<input type="checkbox"/>	UT San Antonio
	<input type="checkbox"/>	UT Austin Dell Medical School	<input type="checkbox"/>	UT HSC San Antonio	<input type="checkbox"/>	UT Permian Basin	<input type="checkbox"/>	UT Southwestern Medical Center
	<input type="checkbox"/>	UT Dallas	<input type="checkbox"/>	UT HSC Tyler	<input type="checkbox"/>	UT Rio Grande Valley	<input type="checkbox"/>	UT Tyler

The monthly rate is to be used in the calculation of your total premium due **only** if the Covered Person has a loss of coverage due to age limitation, etc. The monthly rate would be paid **after the** month in which the qualifying event occurred through the end of the medical coverage period.

Note: This enrollment form is only for a student turning age 19.

PERIOD RATES AND COVERAGE DATES				
COVERAGE DATES		MONTHLY RATE - DENTAL ONLY		*CALCULATE TOTAL PREMIUM DUE
ANNUAL	Qualifying Event Date ____/____/____ through ____/____/____	Coverage	Monthly Rate Dental Only	Example: \$21 x 3 months = \$63
	OR	Qualifying Event Date ____/____/____ through ____/____/____	Student	\$ 21.00
				$\$ \frac{21}{\text{Rate}} \times \$ \frac{\quad}{\# \text{ Months}} = \$ \frac{\quad}{\text{Total}}$
FALL			TOTAL	\$
Coverage may not extend past the termination date of your coverage period				*TOTAL PREMIUM MUST BE PAID IN FULL
				Visit utsystem.myahpcare.com to find the correct Premium Cost for the applicable coverage period.

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 1-855-247-7587.

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 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 <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: _____