Send completed form, required documentation, and premium payment to:
Academic HealthPlans, Inc.
PO Box 1605
Colleyville, TX 76034-1605

Enrollment by Qualifying Event

This form must accompany the Academic HealthPlans Enrollment Form

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

LIST DEPENDENTS TO BE INSURED BELOW

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				/ /		– –

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
	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.	**Letter of Ineligibility (lost coverage) is required for any reason listed.**
☐	Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause) Cause of Loss: _____ _____	Written documentation from insurance company, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
☐	Acquired a new dependent — **spouse** (and adding other previously eligible dependents)	Copy of marriage certificate
☐	Acquired a new dependent — **newborn, adopted child, child arriving from another country** (and adding other previously eligible dependents)	Copy of birth certificate or proof of birth for newborn; or proper visa documentation for child(ren) arriving from another country.

STUDENT SIGNATURE: _____ DATE: _____

ahp Academic HealthPlans℠ | CROSS BENEFIT SOLUTIONS

Worcester Polytechnic Institute 2019 - 2020 Qualifying Event Enrollment Form

STUDENT AND DEPENDENTS

4958622-19

(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**	*(required for **Domestic Students** to activate coverage)* - -	**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 will expire concurrently with that of the student.

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 **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 Blue Shield Massachusetts.**

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

My signature below represents 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 OF CARDHOLDER: _____ DATE: _____

(Signature of Student, or Parent/Guardian 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 →**

ahp Academic HealthPlans | CROSS BENEFIT SOLUTIONS

Worcester Polytechnic Institute 2019 - 2020 Qualifying Event Enrollment Form

STUDENT AND DEPENDENTS

4958622-19

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification: ☐ Graduate Students taking under 7 hours ☐ All Undgrads or Graduate Students taking 7+ hours

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES	Monthly Rate		
	Coverage	Monthly Rate	
Qualifying Event Date **____/____/_____** **through** **08/11/2020**	**Student** *(tuition billed)*	$ 105.00	*(Student premium is charged on tuition bill)*
	Spouse Only	$ 207.24	**The Qualifying Event Date determines the cost of the coverage. We will reach out to you with the total premium amount due.**
	One Child Only	$ 103.96	
	Family*	$ 312.20	
	***Family = Spouse + one or more children or no spouse but more than one child. Coverage includes Pediatric Dental only.**		
	TOTAL PREMIUM MUST BE PAID IN FULL		

PAYMENT FOR STUDENT: Your 2019-2020 insurance premium will be calculated according to the date of your Qualifying Event. The total amount will be charged to your school tuition.

PAYMENT FOR DEPENDENTS: Your 2019-2020 insurance premium will be calculated according to the date of your Qualifying Event. An AHP Representative will reach out to you with the total premium due. Please supply valid and legible email address.

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

PAYMENT CREDIT CARD OPTIONS

PAYMENT FOR DEPENDENTS: Once premium has been determined and you agree with this amount, AHP will charge the premium to the payment method provided. Your card will not be charged without your approval.

Please fax to **1-855-858-1964**

Amount to be charged	$ to be confirmed via email from AHP representative
Credit Card Number	
Expiration Date	(MM/YY) /
Billing Zip Code	

VISA ☐	MasterCard ☐	Discover ☐	AMEX ☐

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of premium. I understand the insurance will be cancelled if the 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: _____