

101227-15 - Medical | 101228-15 - Dental

DOMESTIC AND INTERNATIONAL STUDENT DEPENDENTS

Enrollment will NOT be accepted after the Open Enrollment Period
(see reverse side 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)

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	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 **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 reverse side. **CONTINUE ON REVERSE SIDE →**

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Academic HealthPlans, Inc. (AHP) is a separate company that provides program management and administrative services for the student health plans of Blue Cross and Blue Shield of Texas

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(see dates below)

Student Name: _____

Student ID Number: _____
(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification: 1) ☐ Domestic ☐ International
2) ☐ Art ☐ Business ☐ Engineering ☐ Law ☐ Theology ☐ Other

If the student does not waive the insurance for the fall semester, the charges for the Student Only coverage will be automatically added to your tuition bill for the fall semester. If a student wants to enroll in this coverage, please go to www.smu.edu/healthinsurance for enrollment information. If you want to enroll your dependents, please complete this form and return to Academic HealthPlans. The premium for dependents only must accompany the enrollment form.

PERIOD RATES AND COVERAGE DATES		CALCULATE TOTAL PREMIUM DUE	
Medical	Fall 08/01/2017 through 12/31/2017	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 04/20/2017 to 09/26/2017	<i>Example: Spouse and one child will write: (\$1,399 + \$1,399 = \$2,798)</i>	
Spouse	\$ 1,399.00	\$	
Child	\$ 1,399.00	\$	
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). Your cancelled check or credit card billing is your only receipt and notification of coverage. **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 (855) 357-0242.

PAYMENT OPTIONS							
If paying by credit card fax to (855) 858-1964				By check			
Name as it appears on the card				Make check or money order in U.S dollars payable to		Academic HealthPlans	
Billing Address				Check Amount		\$	
Amount to be charged		\$		Check Number			
Credit Card Number				Mail Check and this enrolment form to		Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605	
VISA		Master Card					

☐ 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: _____

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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 smu.myahpcare.com.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Student/Insured Classification: 1) ☐ Domestic ☐ International
2) ☐ Art ☐ Business ☐ Engineering ☐ Law ☐ Theology ☐ Other

PERIOD RATES AND COVERAGE DATES		CALCULATE TOTAL PREMIUM DUE	
Medical + Dental	Fall 08/13/2016 through 01/09/2017	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 04/20/2016 to 09/26/2016	<i>Example: Student with a Spouse will write: (\$116 + \$1,515 = \$1,631)</i>	
Student (dental only)	\$ 116.00	\$	
Spouse	\$ 1,515.00	\$	
Child (Medical only)	\$ 1,399.00	\$	
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). Your cancelled check or credit card billing is your only receipt and notification of coverage. **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 (855) 357-0242.

PAYMENT OPTIONS							
If paying by credit card fax to (817) 809-4701				By check			
Name as it appears on the card				Make check or money order in U.S dollars payable to		Academic HealthPlans	
Billing Address				Check Amount		\$	
Amount to be charged		\$		Check Number			
Credit Card Number				Mail Check and this enrolment form to		Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605	
VISA	Master Card	Discover	Expiration Date				

☐ 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: _____