BlueCross BlueShield of Texas

SOUTHERN METHODIST UNIVERSITY

101227-14

2014–2015 Student Health Insurance Plan

Fall & Spring/Summer Enrollment Form for Domestic and International Student Dependents

Enrollment will NOT be accepted after September 26, 2014 for the fall and February 20, 2015 for the spring

(PLEASE PRINT CLEARLY or TYPE)

Student's Name	First	Middle Initial	Last		
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)*		**Cell or Telephone Number** ( ) —			
Male	**Female**	**Date of Birth** (Month/Day/Year) / /	**SSN** - -	**School 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 (or within 30 days if tuition billed), 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, therefore will expire concurrently with that of the student.

	First Name	MI	Last Name	Date of Birth (M/D/Y)	Gender (M/F)	Social Security #
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

NOTICE TO STUDENT AND CARDHOLDER: 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 for timely renewal payments. This plan is underwritten by Blue Cross and Blue Shield of Texas.

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.

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.

STUDENT'S SIGNATURE: _____ DATE: _____

(Signature of Student or Parent if Student is under age 18)

CARDHOLDER'S SIGNATURE: _____ DATE: _____

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side

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Student Name_____ **School ID Number**_____

(must be provided to be processed)

Enrollment will NOT be accepted after the Open Enrollment Period. See dates below.

PLEASE CHECK ALL APPROPRIATE BOXES: Hours enrolled: _____

Academic Schools: ❑ Domestic ❑ International ❑ Arts ❑ Business ❑ Engineering ❑ Law ❑ Theology ❑ Other

PERIOD RATES AND COVERAGE DATES:

Insured Type	Fall 08/13/14 through 01/09/15		Spring/Summer 01/10/15 through 08/12/15	
Open Enrollment Periods	05/01/14 - 09/26/14		11/03/14 - 02/20/15	
Spouse		$ 2,870		$ 2,870
Each Child		$ 650		$ 650

If the student does not waive the insurance for the fall and spring semesters, the charges for the Student Only coverage will be automatically added to your tuition bill for the fall and spring semesters. 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.***

(The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments.)

The final cost will include a $15 processing fee. Please use the chart below to calculate total amount due.

CALCULATE TOTAL PREMIUM DUE

Step 1 - Choose all desired premium above **| Step 2 -** Write the amount chosen in the applicable column(s) below **Step 3 -** Calculate and submit total due.

Example: Spouse Rate + Each Child Rate + Processing Fee = Total
($2,870 + $650 + $15 = $3,535)

Spouse Rate		Each Child Rate		Each Child Rate		Processing Fee		Total Amount Due
$	+	$	+	$	+	$15.00	=	$

PAYMENT INFORMATION: Make check or money order payable to **Blue Cross and Blue Shield of Texas** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605 or fax to (817) 809-4701, if paying by credit card.** If you have questions, please call Academic HealthPlans at (855) 357-0242. 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.**

PAYMENT OPTIONS

Charge Full Amount	$					Check Amount	$
	VISA		MasterCard		Discover	Check Number	
Credit Card Number						Expiration Date	_____/_____ Month Year

❑ **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: _____