ahp | Academic HealthPlans

Southern Methodist University 2017-2018
Fall Academic Emergency Services Enrollment Form
STUDENTS AND THEIR DEPENDENTS

The Southern Methodist University students are required to have Medical Evacuation and Repatriation benefits. Students can enroll for the stand-alone Academic Emergency Services (AES) benefits as long as you can provide proof of medical insurance coverage that is comparable to the Southern Methodist University Student Health Insurance Plan. The AES benefits include Medical Evacuation, Repatriation, Accidental Death and Dismemberment, and Travel Assistance. The cost for the AES includes premium for benefits **underwritten by UnitedHealthcare Global.**

Students can enroll in the stand-alone Academic Emergency Services by completing the information required below. This form must be completed in its entirety, signed and returned to Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605.

(PLEASE PRINT CLEARLY or TYPE)

STUDENT INFORMATION									
Student Name	First		Middle Initial		Last				
Local Mailing Address	Street or P.O.Box			City			State	Zip Code	
	(MM/DD/YYYY) / /			**Phone/Cell Number**		( ) —			
Email	*(A confirmation email will be sent upon enrollment)*								
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				/ /		– –

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 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.

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 am currently participating in the insurance Policy listed on the attached copy of my Student Health Insurance Plan card and will continue to participate throughout the school year. I have compared the above Policy with the Student Health Insurance Plan and have determined the benefits to be at least comparable. I further understand that by submitting this enrollment form, I will still be responsible for my medical expenses and neither the university nor its Student Health Insurance Plan program will be responsible for those expenses.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be subject to prosecution for insurance fraud.

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 →**

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

(PLEASE CHECK THE APPROPRIATE BOX)

PERIOD RATES AND COVERAGE DATES			CALCULATE TOTAL PREMIUM DUE
Select Coverage		**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
Each Insured		$ 48.00	#_____ X $ _____ = $ _____ Insured Rate Total
		TOTAL	$

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. 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 enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
VISA		Master Card		Discover		Expiration Date	(MM/YY) /		

☐ **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: _____