ahp | Academic HealthPlans

Send completed form, required documentation, and premium payment to:

Academic HealthPlans, Inc.
P O Box 1605
Colleyville, TX 76034-1605

ENROLLMENT BY QUALIFYING EVENT

This form must accompany the Academic HealthPlans enrollment form.

Student Name (Last, First, MI)			Social Security Number
School Name			Policy Number
List Dependents to be Insured below	Sex	DOB MM/DD/YYYY	SSN
Spouse (Last, First, MI)	M F	___/___/_____	_____ - ____ - _____
Child (Last, First, MI)	M F	___/___/_____	_____ - ____ - _____
Child (Last, First, MI)	M F	___/___/_____	_____ - ____ - _____
Qualifying Event Date			
Student Signature		Date Signed	

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 of the qualifying event. Improper documentation will result in a return of premium and a delay of coverage.**

	Qualifying Event *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.*	**Documentation Required** *Letter of Creditable 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 the school or insurance company on school/company letterhead 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 (**and** adding other previously eligible dependents)	Copy of birth certificate for newborn

FOR USE BY ACADEMIC HEALTHPLANS ONLY		
Date Received	Date Approved/Denied and Reason	Effective Date
Eligibility Representative Signature		Date Signed

BlueCross BlueShield of Texas

101530-14 - Medical
106145-14 - Dental

UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON

2014–2015 STUDENT HEALTH INSURANCE PLAN

1ST YEAR MEDICAL QUALIFYING EVENTS ENROLLMENT FORM

Please complete form below

(PLEASE PRINT CLEARLY or TYPE)

Student's 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)*			**Cell or Telephone Number** ( ) —				
Male		**Female**		**Date of Birth** (Month/Day/Year) / /	**SSN** - -	**UT Login 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. 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.

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

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date **of the Qualifying Event if required documentation and form are received within 31 days of Qualifying Event**, 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.

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

BlueCross BlueShield of Texas

101530-14 - Medical

UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON
2014–2015 STUDENT HEALTH INSURANCE PLAN
1ST YEAR MEDICAL QUALIFYING EVENTS ENROLLMENT FORM

Student Name_____ **UT Login Number**_____
(must be provided to be processed)

PLEASE CHECK ALL APPROPRIATE BOXES:

*The monthly rate is to be used in the calculation of your total premium due **only** if the Covered Person has a qualifying event such as marriage, birth, loss of coverage due to age limitation, etc. The monthly rate would be paid beginning in the month which the qualifying event occurred through the end of the current coverage period. Thereafter, the premium for the full coverage period would need to be paid. For an example of how to calculate total premium, please see the sample calculation below.

PERIOD RATES AND COVERAGE DATES:

Medical Only

	Annual 07/01/14 through 06/30/15	Fall 07/01/14 through 12/31/14	Spring/Summer 01/01/15 through 06/30/15	*Sample Monthly Rate Calculation for Student Only Qualifying event occurs on Oct. 12, 2014 *Student coverage period will begin* Oct. 1, 2014 thru Dec 31, 2015: Qualifying Event Premium 2 *(months)* X $155 *(monthly rate)* + Full Coverage Period Premium $930 *(spring/summer term rate)* = $1,240 *(total premium due - Student Only)* *(Same Calculation for dependent using correct premium)*
Student Only	$ 1,859.00	$ 930.00	$ 930.00	$ 155.00
Spouse	$ 5,266.00	$ 2,633.00	$ 2,633.00	$ 439.00
All Children	$ 2,894.00	$ 1,447.00	$ 1,447.00	$ 242.00

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: Student + Spouse + Processing Fee = Total
($1,859 + $5,266 + $15 = $7,140)

Student Rate	Spouse Rate	All Children 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) 247-7587. 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 _____

BlueCross BlueShield of Texas

101530-14 - Medical | 106145-14 - Dental

UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON

2014–2015 STUDENT HEALTH INSURANCE PLAN

1ST YEAR MEDICAL QUALIFYING EVENTS ENROLLMENT FORM

Student Name_____ **UT Login Number** _____

(must be provided to be processed)

PLEASE CHECK ALL APPROPRIATE BOXES:

Optional dental coverage is only available to the student and Dependent spouse.
The Medical and Dental combined rates do not include a dental rate for children, only the medical rate is included.

PERIOD RATES AND COVERAGE DATES:

Medical + Dental		**Annual 07/01/14 through 06/30/15**		**Fall 07/01/14 through 12/31/14**		**Spring/Summer 01/01/15 through 06/30/15**
Student Only		$ 2,100.00		$ 1,051.00		$ 1,051.00
Spouse		$ 5,507.00		$ 2,754.00		$ 2,754.00
All Children* *(Medical Only)*		$ 2,894.00		$ 1,447.00		$ 1,447.00

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: Student + Spouse + Processing Fee = Total
($2,100 + $5,507 + $15 = $7,622)

Student Rate	Spouse Rate	All Children Rate	Processing Fee	Total Amount Due
$	$	$	$15.00	$

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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 _____