Indiana University International 2016-2017 Dependent Enrollment Form

(PLEASE COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM)

All information must be complete and the appropriate premium received by the deadlines listed below in order to process your application.

ELIGIBILITY TO PARTICIPATE IN THIS PLAN:

- **Spouse/Domestic Partner and/or dependent children** may be enrolled in the Plan only if the student is also insured by the IU International Student Insurance Plan. The Spouse/Domestic Partner must be residing with the insured and dependent children must 26 years of age or under.

Enrollment Deadlines

Enrollment applications must be received by Aetna Student Health no later than the dates indicated below. If the deadline has passed, you may enroll for coverage beginning with the next coverage period, provided an application and appropriate premium have been received by Aetna Student Health prior to or on the established deadline.

Enrollment Period	Deadline
Annual/Fall 2016	September 15, 2016
Spring/Summer 2017	January 31, 2017
Summer 2017	June 15, 2017
Quarterly 2016/2017*	September 15, 2016*

***If a quarterly payment is missed the dependent(s) will not be able to enroll until the next open enrollment period and a break in coverage will apply. The 2nd quarter deadline is 11/10/16. The 3rd quarter deadline is 2/10/17 and the 4th quarter deadline is 5/10/17.**

Enrollment after the deadlines specified above is allowed only for the loss of other health insurance coverage, marriage or the birth/adoption of a child. You must contact Aetna Student Health ***within 31 days of losing other coverage, marriage, or birth/adoption of a child***.

(PLEASE PRINT)

Step One: Provide Student/Dependent Information

Student's Name: _____ Indiana University Student ID#: _____
Last First MI

Permanent **U.S. Address**: Street or P. O. Box: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Date of Birth: _____ ☐ Male ☐ Female E-Mail Address: _____
mm/dd/yy

List dependents to be insured below. Dependent Coverage is available using this enrollment form only if the student is also insured under this Plan.

Last Name	First Name	M.I.	Relationship	Date of Birth	Social Security No.	Gender
_____	_____	_____	Spouse/DP	___/___/___	___-___-___	☐ M ☐ F
_____	_____	_____	Child	___/___/___	___-___-___	☐ M ☐ F
_____	_____	_____	Child	___/___/___	___-___-___	☐ M ☐ F
_____	_____	_____	Child	___/___/___	___-___-___	☐ M ☐ F

Step Two: Select Appropriate Enrollment Period and Rates

Basic Plan **812849-DINT19**	**Annual** 8/1/16 - 7/31/17	**Fall** 8/1/16 - 12/31/16	**Spring/Summer** 1/1/17 - 7/31/17	**Summer** 6/1/17 – 7/31/17
Spouse/Domestic Partner	☐ $1,720	☐ $721	☐ $999	☐ $288
Child	☐ $1,720	☐ $721	☐ $999	☐ $288
Children	☐ $3,440	☐ $1,442	☐ $1,998	☐ $576

Basic Plan 812849-DINT19	Quarter 1 8/1/16 - 11/9/16	Quarter 2 11/10/16 - 2/9/17	Quarter 3 2/10/17 - 5/9/17	Quarter 4 5/10/17 - 7/31/17
Spouse/Domestic Partner	☐ $430	☐ $430	☐ $430	☐ $430
Child	☐ $430	☐ $430	☐ $430	☐ $430
Children	☐ $860	☐ $860	☐ $860	☐ $860

PLEASE READ AND SIGN THIS FORM BELOW. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →

***Please note: Quarterly payment option is only available for those enrolling at the beginning of the academic year for 2016-2017. The deadline to enroll in the quarterly payment option is September 15, 2016.**

If a quarterly payment is missed the student and dependent(s) will not be able to enroll until the next open enrollment period and a break in coverage will apply. The 2nd quarter deadline is 11/10/16. The 3rd quarter deadline is 2/10/17 and the 4th quarter deadline is 5/10/17.

Step Three: Designate Payment Method

Make check or money order payable to Aetna Student Health or refer to the charge card authorization to charge premium to Visa, MasterCard, Discover or American Express. CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY (PLEASE NOTE THE ONLY ACCEPTED CREDIT CARDS).

Charge Full Amount: $☐☐☐☐.☐☐

Credit Card# (Visa, MasterCard, Discover or American Express only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date: ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address (if different from student):

Step Four: Notice to student (Signature Required)

Coverage will be effective retro-active to the appropriate effective date if the correct premium is received by the Company or a representative of the Company. Applications postmarked after the deadline will not be accepted and will be returned. **It is the student's responsibility for timely renewal payments.** By signing below, the student acknowledges the following: 1) He/She has carefully read the Plan Design and Summary of Benefits and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described in the Plan Design and Summary of Benefits; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than eligibility, **the premium is not refundable.**
The information contained on this form is confidential and will not be released unless the student named in this form provides written authorization, except to comply with state or federal law or a court order. This information may also be released in the event of an emergency hospitalization, or in other circumstances which pose a threat to life or serious immediate physical harm.

Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

SIGNATURE OF STUDENT: _____ **DATE:** _____

PLEASE RETURN THIS FORM TO:
Aetna Student Health, P.O. BOX 14388, Lexington, KY 40512