**Aetna Life Insurance Company** **Aetna Student Health**

# University of Missouri-St. Louis (UMSL)– 2013/2014
# Dependents of International Students
# Student Health Insurance Enrollment Form

***In order to enroll you must complete steps 1 through 5!***

1. ***Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 877-375-7905 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.***

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Student Name: _____ _____ _____
Last Name First Name MI

Student ID #: _____

Email address: _____

Mailing Address: _____ _____
This address will be used for all Aetna Student Health insurance communications Apt.#

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female
mm/dd/yy

2. List Dependents to be insured. Dependent coverage is only available if the student is covered. ***Dependents must be enrolled within 30 days of the later date of: a) the student's effective date of coverage, or b) the date the dependent entered the USA.***

| Dependents | Last Name | First Name | DOB | Social Security Number | M/F |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

3. ***Select Enrollment Plan***

| **Form ID: 890440-DINT16** | **A.** | **B.** | **C.** | **D.** |
|---|---|---|---|---|
| **Basic Plan** | **Annual Effective Date: 08/01/13-07/31/14 Deadline: 09/13/13** | **Fall Effective Date: 08/01/13-12/31/13 Deadline: 09/13/13** | **Spring/Summer Effective Date: 01/01/14-07/31/14 Deadline: 02/14/14** | **Summer Effective Date: 06/01/14-07/31/14 Deadline:06/13/14** |
| 1. Spouse | ☐ **$6,792** | ☐ **$2,847** | ☐ **$3,945** | ☐ **$1,135** |
| 2. Child(ren) | ☐ **$2,545** | ☐ **$1,067** | ☐ **$1,478** | ☐ **$425** |
| **Total** | | | | |

**PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.**

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

**WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →**

***4. Designate Payment Method.***

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

**CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!! (VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER)**

**Charge full amount: $**□□□□.□□

**Credit Card# :** □□□□□□□□□□□□□□□□

**Exp. Date:** □□/□□

**Signature of Cardholder:**_____

**Printed Name and Address (if different from student):**

***5. Notice to Student (Signature required)***

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit UMSL to provide Aetna Student Health with enrollment status for purposes of eligibility under this plan**. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) can be made void. I understand that if it is later determined that I am not eligible **(see the brochure, pamphlet or Master Policy for eligibility guidelines),** the premium will be refunded, but the premium is not refundable for reasons other than eligibility**.**

**It is the student's responsibility for timely renewal payments.**

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. When applying due to a life event, please attach appropriate documentation providing proof and date of the event.**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

**Signature**: _____**Date**:_____

**SPECIAL MISSOURI NOTICE**

**An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs.**
**Your group contract holder has not purchased an optional rider for elective abortions pursuant to VAMS section 376.805.**

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