University of Missouri – St. Louis (UMSL) 2009-2010
OPT Student Enrollment Form & Dependent of International Students
Accident and Sickness Insurance Plan Enrollment Form

1. Complete all Student information and return the application and premium payment to the address listed below.

Student Name: _____
Last Name First Name MI

School Issued ID/Social Security #:_____ Email Address: _____

Mailing Address: _____
Apt. #

City: _____State:_____ Zip Code: _____

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

2. List the 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					

3. Select enrollment Period.

890440	Annual 08/01/09 – 07/31/10 Deadline: 9/18/09	Fall 08/01/09– 12/31/09 Deadline: 9/18/09	Spring/Summer 01/01/10 – 07/31/10 Deadline: 2/12/10	Summer 06/01/10- 07/31/10 Deadline: 6/18/10
Student 890440-OPT12	☐ $1,080	☐ $450	☐ $630	☐ $181
Student & Spouse 890440-OPT12-1	☐ $5,976	☐ $2,490	☐ $3,486	☐ $1,000
Student & Child(ren) 890440-OPT12-2	☐ $2,915	☐ $1,215	☐ $1,700	☐ $488
Student & Spouse & Child(ren) 890440-OPT12-3	☐ $7,810	☐ $3,255	☐ $4,555	☐ $1,307

4. *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 or MasterCard (Please note Visa and MasterCard are the only credit cards accepted). CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION - PLEASE PRINT CLEARLY

Charge TOTAL PAYMENT amount: $☐☐☐.☐☐

Credit Card (Visa or MasterCard only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp. Date:** ☐☐/☐☐

Signature of Cardholder:

Printed Name and Address (if different from Student):

5. Notice to Student (Signature Required)

I have carefully read the brochure and elect to enroll myself and my dependents as indicated. I permit UMSL to provide Aetna Student Health with my 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 the student is not eligible for coverage, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

***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: _____

MAIL TO: Aetna Student Health P.O. Box 15706, Boston, MA 02215-0014