

University of Missouri-St. Louis (UMSL)

2011/2012 Visiting Scholar

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

Visiting Scholar Name: \_\_\_\_\_  
Last Name First Name MI

Scholar ID/Social Security #: \_\_\_\_\_

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 Visiting International Scholar is covered.

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

3. Premium Rates

Coverage will begin on the day after payment is submitted. It is my responsibility to make timely payments. Eligible Visiting International Scholars and their eligible dependents whom enroll in the school-sponsored scholar health insurance plan after the 15th of a given month will be charged for one-half of the monthly premium. **NOTE:** This option is available only in the first month of coverage based on the initial effective date. Full payment is due at the time of initial enrollment. The half monthly rate is only available to Scholar/Dependents that enter the U.S. after the 15<sup>th</sup> of the month. Coverage will be effective the day the Scholars/Dependent enters the U.S. Students/Dependents must enroll within 31 days of entering the US.

B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12
August '11	Sept '11	Oct '11	Nov '11	Dec '11	Jan '12	Feb '12	March '12	April '12	May '12	June '12	July '12

\*\* Coverage will be effective from \_\_\_\_\_ to \_\_\_\_\_  
month/day/year month/day/year

\*\* Coverage is only for the 2011/2012 academic year which is between 8/01/11 and 7/31/12.

	½ Month Rate 890440-V14-1	Monthly Rate 890440-V14
Visiting Scholars	<input type="checkbox"/> \$52.50	<input type="checkbox"/> \$105.00
Spouse	<input type="checkbox"/> \$237.00	<input type="checkbox"/> \$474.00
Child(ren)	<input type="checkbox"/> \$90.00	<input type="checkbox"/> \$180.00

Number of Months Requested	X	Monthly Premium	=	TOTAL PREMIUM
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**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 or MasterCard (please note Visa and MasterCard are the only credit cards accepted). **CASH WILL NOT BE ACCEPTED.**

**CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!! (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)**

Charge full 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 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:** \_\_\_\_\_

**ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:  
AETNA STUDENT HEALTH BENEFIT P.O. BOX 15706, BOSTON, MA 02215-0014**