Aetna Life Insurance Company

Aetna Student Health

Arizona State University-Dependent Only Insurance Plan 2013/2014 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 866-378-0178 for assistance.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Student Name:	Last Name				Firs	t Name			ΜΙ
Student ID/#:									
Email address:									
Mailing Address		ill be used for all Aetna S	Student Health insurance	communications				Apt.#	
City:						Sta	ate: Zip	Code:	
Phone Number:					e of Birth:	mm/dd/yy		Sex: □ Male □ Fema	ile
2. List Depend	<u>lents to be ins</u>	ured. Depende	nt coverage is	only available	e if the studen	t is covered.			
Dependents Spouse	Last Name		First Nan	ne	D	ОВ	Social Security Number		M/F
Child									
Child									
Child									†
Child									1
3 Select F	nrollment Pla	n							
Form ID: 697443- D16-3	noument 1 ta	n.							
Dependent Enrollment	Fall A 8/16/13- 10/15/13 Deadline: 9/15/13	Fall B 10/16/13- 1/3/14 Deadline: 10/29/13	Spring A 1/4/14- 3/16/14 Deadline: 1/26/14	Spring B 3/17/14- 8/15/14 Deadline: 3/30/14	Summer A 5/16/14- 8/15/14 Deadline: 6/2/14	Summer B 7/1/14- 8/15/14 Deadline: 7/16/14			
1. Spouse	□ \$943	□ \$1,236	□ \$1,113	□ \$2,348	□ \$1,422	□ \$711			
2. Child(ren)	□ \$806	□ \$1,058	□ \$952	□ \$ 2,008	□ \$1,216	□ \$608			
3. Spouse & Child(ren)	□ \$1,346	□ \$1,764	□ \$1,588	□ \$ 3,354	□ \$2,030	□ \$1,015			
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 & 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: Exp. Date: (Visa, MasterCard, Discover & American Express only)
(Visa, MasterCard, Discover & American Express only)
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 Arizona State University 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.
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*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.
Signature:Date:

ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO: Aetna Student Health P.O. Box 14388, Lexington, KY 40512 Fax – 859-425-5200