

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

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:

mm/dd/yy

Sex: ☐ Male ☐ Female**2. List Dependents to be insured. Dependent coverage is only available if the student is covered.**

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

3. Select Enrollment Plan

Form ID:			
Dependent Enrollment	Fall 8/16/13- 1/3/14 Deadline: 9/15/13	Spring 1/4/14- 8/15/14 Deadline: 1/26/14	Summer 5/16/14- 8/15/14 Deadline: 6/2/14
1. Spouse 697443-D16	<input type="checkbox"/> \$2,179	\$3,461	<input type="checkbox"/> \$1,422
2. Child(ren) 697443-D16-1	<input type="checkbox"/> \$1,864	<input type="checkbox"/> \$2,960	<input type="checkbox"/> \$1,216
3. Spouse & Child(ren) 697443-D16-2	<input type="checkbox"/> \$3,110	<input type="checkbox"/> \$4,942	<input type="checkbox"/> \$2,030
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.

My signature provides authorization to charge my credit card or checking account for the 1st payment at the time of application and continued Semester debits for the remainder of the policy year. If for any reason my credit card or checking account does not accept the debit, an alternate credit card payment must be provided prior to the published deadline.

On 12/4/13, your credit card or checking account will automatically be charged for the next semester's premium. For any reason, if the charge is unable to be processed, a warning letter will be sent to your address on file.

The card or checking account will be attempted again on 12/19/13. If the charge fails on 12/19/13, a termination letter will be sent notifying you that payment has failed and if alternate payment is not received by the published deadline, coverage will be terminated.

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.

[illegible]

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.

***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