Indiana University Undergraduate & Graduate
2014-2015 Student Health Insurance Plan Enrollment Form
(Please complete both sides of this enrollment form)
All information must be complete and the appropriate premium received in order to process your application

Eligibility to participate in this plan:

- Domestic Undergraduate taking 6 or more credits.
- Domestic Graduate Students taking 3 or more credit hours or registered for thesis or dissertation are eligible to enroll in this insurance plan.

Enrollment deadlines
Enrollment applications must be postmarked no later than the dates indicated below. If the deadline has passed, you may enroll for coverage beginning with the next coverage period, provided an application and appropriate premium have been received by Aetna Student Health prior to or on the established deadline.

<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual/Fall 2014</td>
<td>September 15, 2014</td>
</tr>
<tr>
<td>Spring 2015</td>
<td>January 31, 2015</td>
</tr>
</tbody>
</table>

Enrollment after the deadlines specified above is allowed only for the loss of other health insurance coverage. You must contact Aetna Student Health within 31 days of losing other coverage.

(Please print)

Step One: Provide Student Information

Student’s Name: ____________________________________________________________________________ Student’s ID#: _______________________________________

Last First MI

Permanent U.S. Address: ___________________________________________________________ City:  _________________________State:  ___________ Zip Code: ___________

Phone Number: (______) ________________________ Date of Birth: _____________ Male          Female     E-Mail Address: ____________________________

Step Two: Select Student Enrollment Group

VOLUNTARY
890423-BSD17

☐ Domestic Undergraduate @ IUB     ☐ Domestic Undergraduate @ IUPUI

☐ Domestic Graduate @ IUB          ☐ Domestic Graduate @ IUPUI

☐ Domestic Undergraduate @ Regional Campus *     ☐ Domestic Graduate @ Regional Campus *

*Regional Campus = East, Kokomo, Northwest, South Bend, Southeast

Step Three: Select Appropriate Enrollment Period and Rates

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Annual</th>
<th>Fall</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>8/15/14 - 8/14/15 Deadline 9/15/14</td>
<td>8/15/14 - 12/31/14 Deadline 9/15/14</td>
<td>1/01/15 - 8/14/15 Deadline 1/31/15</td>
</tr>
<tr>
<td>1. Voluntary Student Health Insurance Plan</td>
<td>☐ $3,020</td>
<td>☐ $1,150</td>
<td>☐ $1,870</td>
</tr>
</tbody>
</table>

PLEASE READ AND SIGN THE SECOND PAGE OF THIS FORM. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.
Step Four: 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, MasterCard, Discover or American Express. CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION—PLEASE PRINT CLEARLY (PLEASE NOTE THE ONLY ACCEPTED CREDIT CARDS)

Charge full amount: $________________________

Credit card# (Visa, MasterCard, Discover or American Express only): ____________________________ Exp.

Date: ___/___/____

Signature of Cardholder:__________________________________________________________________

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

Step Five: Notice to Student (Signature Required)

Coverage will be effective retro-active to the appropriate effective date if the correct premium is received by the Company or a representative of the Company. Applications postmarked after the deadline will not be accepted and will be returned. It is the student’s responsibility for timely payments. By signing below, the student acknowledges the following: 1) He/She has carefully read the Plan Design and Summary of Benefits and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described in the Plan Design and Summary of Benefits; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than eligibility, the premium is not refundable.

The information contained on this form is confidential and will not be released unless the student named in this form provides written authorization, except to comply with state or federal law or a court order. This information may also be released in the event of an emergency hospitalization, or in other circumstances which pose a threat to life or serious immediate physical harm.

SIGNATURE OF STUDENT: ___________________________________________ DATE: ____________

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