

**Indiana University
2008/2009 Intensive English Program (IEP) Enrollment Form**

In order to enroll you must complete steps 1 through 5!

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 (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)

Charge full amount: \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Credit card# (Visa or MasterCard only): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Exp. Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
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 as indicated. I permit Indiana University 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/qualifying domestic partner 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.

Signature: _____ Date: _____

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

Indiana University Authorization: (must be completed by an authorized Indiana University employee):

This is to verify that _____ is required to purchase insurance coverage as a Student of Indiana

University's Intensive English Program in Session _____
List session

Print Name

Signature

Date