Indiana University
2008/2009 Visiting Scholar Enrollment Form

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

1. Complete all Scholar information. Incomplete information will delay processing.

Scholar Name: _____
Last Name First Name Middle Initial

University ID #: _____ Email Address: _____

U.S. Mailing Address: _____
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 Scholar is covered.

Dependents	Last Name	First Name	DOB	Social Security Number	M/F
Spouse/Same Sex Domestic Partner*					
Child					
Child					
Child					

***Please note: If you are enrolling your same-sex domestic partner, please contact the Campus Student Insurance Coordinator at (812) 856-4650 to complete the domestic partner statement.**

3. Select Enrollment Period

School Attending/Please Check One: Bloomington Campus Indianapolis Campus

812849-VS11	**Annual** (Only available to Visiting Scholars attending IU for the entire academic year.) 8/15/08-8/14/09 Deadline: 9/15/08	**Fall** (Only available to Visiting Scholars attending IU for the fall semester only.) 8/15/08-12/31/08 Deadline: 9/15/08	**Spring/Summer** (Only available to Visiting Scholars attending IU for the spring semester only.) 1/1/09-8/14/09 Deadline: 2/1/09	**Monthly*** (Available to all Visiting Scholars) Deadline: 30 days after effective date	
				Effective Date	**Termination Date**
Scholar	☐ $932	☐ $355	☐ $577	**# of Days:**	**x $2.56=**
				# of Months:	**x $77.67=**
Spouse /Same Sex Domestic Partner*	☐ $2,228	☐ $849	☐ $1,379	**# of Days:**	**x $6.11=**
				# of Months:	**x $185.67=**
Child(ren)	☐ $1,692	☐ $643	☐ $1,049	**# of Days:**	**x $4.64=**
				# of Months:	**x $141.00=**
Total Payment	$_____	$_____	$_____	$	

Enrollments less than two month: Please pay the full premium for the exact number of months and days you will be enrolled in the plan.
Enrollments of two months or more: You may pay your premium in installments. Your first payment must cover at least 2 months.

PLEASE READ AND SIGN THE SECOND PAGE OF THIS FORM. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →

* Below are general guidelines for Visiting Scholars selecting the monthly enrollment option:

- A minimum of two months must be purchased at the initial time of enrollment. Premiums may also be prorated should your coverage begin any day other than the 15th of the month. Please consult with the International Office to calculate the first payment.
- A monthly premium reminder will be sent as a courtesy 20 days before the renewal date. It is ultimately the Visiting Scholar's responsibility to ensure premiums before the deadline. In the event a reminder is not received, the Visiting Scholar should complete a new Enrollment Form and submit it with the premium.
- Payments postmarked after the deadline will be declined, and the Visiting Scholar will need to complete a new Enrollment Form, and will have coverage effective on the 15th of the following month. This will result in a break in coverage.

4. ***Designate Payment Method.***

☐ **check or money order payable to Aetna Student Health.**

☐ **charge card authorization. Please complete below.**

CASH WILL NOT BE ACCEPTED.

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

Total payment amount at this time (from page one of the enrollment form): $☐☐☐☐.☐☐

Credit card# (Visa or MasterCard only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp. Date:** ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address(if different from Scholar):

5. Notice to Scholar (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 Scholar 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 "Visiting Scholar"

from _____ (date) to _____ (date).

_____ _____ _____

Print Name ***Signature*** ***Date***