

6. Notice to Student (Signature required)

On behalf of myself and the dependents listed on the previous page, I agree to or with the following:

1. To enroll, complete the enrollment form and remit the appropriate premium prior to the deadline date. Applications and premium received after the stated deadline date will not be accepted and premium will be refunded. The period of coverage must be selected, and the applicable premium must be paid, at the time of enrollment. There is no renewable option and no refunds are available.
2. I acknowledge that by enrolling in an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my institution or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on the Enrollment/Change Request form. I further authorize Aetna to use such information an to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of this coverage and so long thereafter as allows by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. NOTICE: Aetna does not request information for genetic testing and does not subject insured to genetic testing.
5. The plan documents will determine the rights and responsibilities of member(s) ad will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
6. I understand and agree that all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Signature Required:

Signature: _____ Date: _____

MAIL TO: AETNA STUDENT HEALTH P.O. BOX 15706, BOSTON, MA 02215-0014