

# Indiana University SAA & Fellowship Recipients 2008/2009 Dependent Enrollment Form

## (PLEASE COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM)

All information must be complete and the appropriate premium received by the deadlines listed below in order to process your application.

**ELIGIBILITY TO PARTICIPATE IN THIS PLAN:**

- **Spouse and/or dependent children** may be enrolled in the Plan only if the student is also insured by the IU SAA/Fellowship Recipient Student Insurance Plan. Spouse must be residing with the insured and dependent children must be unmarried, under 19 years of age, not self-supporting, and residing with the insured.

**Enrollment Deadlines**

Enrollment applications must be received by Aetna Student Health 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.

Enrollment Period	Deadline
Annual/Fall, 2008	September 15, 2008
Spring/Summer, 2009	January 31, 2009
Quarterly, 2008/2009*	September 15, 2008*

\*If a quarterly payment is missed the dependent(s) will not be able to enroll until the next open enrollment period and a break in coverage will apply. The 2<sup>nd</sup> quarter deadline is 11/15/078 The 3<sup>rd</sup> quarter deadline is 2/15/09 and the 4<sup>th</sup> quarter deadline is 5/15/09.

Enrollment after the deadlines specified above is allowed only for the loss of other health insurance coverage, marriage or the birth/adoption of a child. You must contact Aetna Student Health *within 31 days of losing other coverage, marriage, or birth/adoption of a child.*

(PLEASE PRINT)

**Step One: Provide Student/Dependent Information**

Student's Name \_\_\_\_\_ Indiana University Student ID# : \_\_\_\_\_  
Last First MI

Permanent U.S. Address: Street or P. O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female E-Mail Address \_\_\_\_\_  
MM/DD/YYYY

List Spouse/Dependents to be insured below. Spouse/Dependent Coverage is available using this enrollment form only if the student is also insured under this Plan.

<u>Last Name</u>	<u>First Name</u>	<u>M.I.</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Social Security No.</u>	<u>Gender</u>
_____	_____	_____	Spouse	___/___/___	___-___-___	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	___/___/___	___-___-___	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	___/___/___	___-___-___	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	___/___/___	___-___-___	<input type="checkbox"/> M <input type="checkbox"/> F

**FORM ID#812849-D11**

**Step Two: Select Appropriate Enrollment Period and Rates**

Basic Plan	Annual A 8/15/08- 8/14/09	Quarterly* B 8/15/08-11/14/08  11/15/08-2/14/09  2/15/09-5/14/09  5/15/09-8/14/09	Fall C 8/15/08- 12/31/08	Spring/Summer q 1/01/09- 8/14/09
<b>2. Spouse</b>	<input type="checkbox"/> \$ 3,980	<input type="checkbox"/> \$ 995*	<input type="checkbox"/> \$ 1,516	<input type="checkbox"/> \$ 2,463

