Indiana University International 2010-2011 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 International Student Insurance Plan. Spouse must be residing with the insured and dependent children must be unmarried, under 24 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, 2010	September 15, 2010
Spring/Summer, 2011	February 1, 2011
Quarterly, 2010/2011*	September 15, 2010*

***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 2nd quarter deadline is 11/15/10. The 3rd quarter deadline is 2/15/11 and the 4th quarter deadline is 5/16/11.**

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 Code: ___________

Phone Number: (_____) ________________ Date of Birth: ______________ (mm/dd/yy) ☐ Male ☐ Female E-Mail Address: ____________________

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

Last Name	First Name	M.I.	Relationship	Date of Birth	Social Security No.	Gender	
__________	__________	______	Spouse*	____/____/____	_____-_____-_______	M	F
__________	__________	______	Child	____/____/____	_____-_____-_______	M	F
__________	__________	______	Child	____/____/____	_____-_____-_______	M	F
__________	__________	______	Child	____/____/____	_____-_____-_______	M	F

***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.**

Step Two: Select Appropriate Enrollment Period and Rates

Basic Plan 812849-DINT13	Annual 8/15/10-8/14/11	Quarterly* 8/15/10-11/14/10 11/15/10-2/14/11 2/15/11-5/14/11 5/15/11-8/14/11	Fall 8/15/10-12/31/10	Spring/Summer 1/01/11-8/14/11
1. Spouse	☐ $2,133	☐ $533*	☐ $813	☐ $1,320
2. Child(ren)	☐ $1,619	☐ $405*	☐ $616	☐ $1,004

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

*Please note: Quarterly payment option is only available for those enrolling at the beginning of the academic year for 2010-2011. The deadline to enroll in the quarterly payment option is September 15, 2010.

If a quarterly payment is missed the student and dependent(s) will not be able to enroll until the next open enrollment period and a break in coverage will apply. The 2nd quarter deadline is 11/15/10. The 3rd quarter deadline is 2/15/11 and the 4th quarter deadline is 5/16/11.

Step Three: 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. CASH WILL NOT BE ACCEPTED.

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

Charge Full Amount: $☐☐☐☐.☐☐

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

Signature of Cardholder:____
Printed Name and Address(if different from student):

Step Four: 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 renewal payments.** By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure 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 brochure; 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, Inc. P.O. Box 15706, Boston, MA 02215-0014