**Aetna Life Insurance Company** **Aetna Student Health**

# Michigan State University-Visiting Scholars
# 2008/2009 Student Health Insurance Enrollment Form

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

***1. Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 800-859-8452 for assistance.***

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Student Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐
Last Name First Name MI

MSU APID Number: ☐☐☐☐☐☐☐☐

Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐
This address will be used for all Aetna Student Health communications 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 student is covered.***

| Dependents | Last Name | First Name | DOB | Social Security Number | M/F |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

***3. Select Enrollment Plan***

| Basic | A | B |
|---|---|---|
| **711130-VS11** | **8/15/08-8/14/09 deadline: 9/30/08** | **Weekly** Please multiply the rate and number of weeks to get your total premium.** |
| 1. Scholar | ☐ **$1,390** | ☐ **$27 X _____(# of weeks) = $_____** |
| 2. Spouse | ☐ **$4,008** | ☐ **$77 X _____(# of weeks) = $_____** |
| 3. One Child | ☐ **$2,152** | ☐ **$41 X _____(# of weeks) = $_____** |
| 3. All Children | ☐ **$2,995** | ☐ **$58 X _____(# of weeks) = $_____** |

****PLEASE FILL IN THE DATES FOR WHICH YOU ARE REQUESTING COVERAGE!**
**EFFECTIVE DATE_____/_____/_____ TERMINATION DATE_____/_____/_____**

**Coverage dates may not extend beyond August 14, 2009. New rates will apply after that date.**

| Catastrophic | A |
|---|---|
| **711130-S11** | **Catastrophic coverage will correspond with Basic coverage dates.** |
| 1. Scholar | ☐ **$555** |
| 2. Spouse | ☐ **$555** |
| 3. Child(ren) | ☐ **$555 X __# of Children** |

**Please Note:**

- **Optional Catastrophic coverage may only be purchased in conjunction with the Basic Coverage at the time of initial enrollment.**
- **Optional Catastrophic must be purchased by the scholar in order to purchase it for dependents.**

**PLEASE COMPLETE AND SIGN THE SECOND PAGE OF THIS FORM.**
**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**
**WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →**

***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: $**☐☐☐☐.☐☐

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

**Signature of Cardholder:** _____

**Printed Name and Address(if different from student):**

***5. Notice to Student (Signature required)***

Enrollment Guidelines: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of coverage period, whichever is later, unless otherwise stated by the Master Policy. **It is the student's responsibility for timely renewal payments.**

I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. I permit Michigan State 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 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. **Coverage may not extend beyond August 14, 2009. It you are eligible for additional coverage, new rates may apply.**

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: _____Date: _____

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