Michigan State University
2008-2009 SUPPLEMENTAL REPATRIATION AND MEDICAL EVACUATION ENROLLMENT FORM
In order to enroll step 1 through 5 must be completed!

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

Student Name: _____
Last Name First Name Middle Initial

MSU STUDENT AP ID#: _____ Email Address: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone Number: (_____) _____Date of Birth: _____/_____/_____ Sex ☐ M ☐ F

Check One: ☐ Undergraduate ☐ Graduate ☐ Visiting Scholar

2. *List the 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. Please complete all enrollment information.

Supplemental Repatriation and Medical Evacuation is available for purchase by Non-immigrant International Students, Visiting Scholars and Visiting Faculty who have prior qualifying coverage for medical care as outlined in the MSU Student Health Insurance brochure and require only coverage for medical evacuation and repatriation benefits. Dependents are eligible ***only*** if the student has or is enrolling for the supplemental repatriation/medical evacuation coverage.

711130-SR11	**A** **Annual 8/15/08-8/14/09 Deadline 09/30/08**	**A** **Spring/Summer 1/01/09-8/14/09 Deadline 01/31/09**
(1) Student	☐ **$66**	☐ **$36**
(2) Spouse	☐ **$66**	☐ **$36**
(3) Child	☐ **$66 x _____ #of Children**	☐ **$36 x _____ #of Children**
Total Premium Due:	**$ _____**	**$ _____**

*This coverage provides unlimited medical evacuation and repatriation, and 24 hour travelers assistance.

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 not Visa and MasterCard are the only credit cards accepted).

Credit Card Authorization – Please be sure to print clearly.

Charge Full amount: $_____

Credit Card (MasterCard or Visa Only) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Signature of Cardholder _____

Printed name and address of cardholder, if different from above.

5. Notice to Student(signature required)

I have carefully read the brochure and elect as indicated. Rates are not pro-rated other than as listed. I permit Michigan State University to provide Aetna Student Health with my student 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, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

Student: _____Date: _____

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