

SOUTHERN METHODIST UNIVERSITY
INTERNATIONAL ACADEMIC EMERGENCY SERVICES
2012 SPRING ENROLLMENT FORM

Southern Methodist University International Students are required to have Medical Evacuation and Repatriation benefits. International Students can enroll for the stand-alone Academic Emergency Services benefits as long as you can provide proof of medical insurance coverage that is comparable to the Southern Methodist University Student Health Insurance Plan. The Academic Emergency Services benefits include Medical Evacuation, Repatriation, Accidental Death and Dismemberment and Travel Assistance. The cost for Academic Emergency Services includes premium for benefits underwritten by ACE American Insurance Company.

Students can enroll in the stand-alone International Academic Emergency Services by completing the information required below. This form must be completed in its entirety, signed and returned to:

ACADEMIC HEALTHPLANS PO Box 1605 COLLEYVILLE, TX 76034

Student's Name		First	Middle Initial	Last
Permanent Address		Street or P.O.Box	City	
Email <small>(A confirmation email will be sent to this address)</small>		Cell or Telephone Number () —		
Male	Female	Date of Birth <small>(Month/Day/Year)</small> / /	SSN - -	Student ID #

	YES	<i>I want to purchase the stand-alone Academic Emergency Services coverage. I have attached proof of my comparable medical insurance coverage that will cover me throughout the entire time that I am a student at Southern Methodist University.</i>
--	------------	--

Payment Information

For coverage from 01/10/12 through 08/12/12

Please charge my credit card for \$40.00	Check enclosed for \$40.00 made payable to:																												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Visa</td> <td style="width: 33%;"><input type="checkbox"/> MasterCard</td> <td style="width: 33%;"><input type="checkbox"/> Discover</td> </tr> <tr> <td colspan="3">Credit Card #</td> </tr> <tr> <td colspan="3">Expiration Date /</td> </tr> <tr> <td colspan="3">Printed Name of Cardholder</td> </tr> <tr> <td colspan="3">Authorized Charge Amount \$</td> </tr> <tr> <td colspan="3"><i>I hereby authorize Academic HealthPlans to deduct the total amount due from my credit card.</i></td> </tr> <tr> <td colspan="3">Signature of Cardholder</td> </tr> <tr> <td colspan="3">Date / /</td> </tr> </table>	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	Credit Card #			Expiration Date /			Printed Name of Cardholder			Authorized Charge Amount \$			<i>I hereby authorize Academic HealthPlans to deduct the total amount due from my credit card.</i>			Signature of Cardholder			Date / /			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 20px;">Academic HealthPlans</td> </tr> <tr> <td>Check Number</td> </tr> <tr> <td>Check Amount</td> </tr> <tr> <td>\$</td> </tr> </table>	Academic HealthPlans	Check Number	Check Amount	\$
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover																											
Credit Card #																													
Expiration Date /																													
Printed Name of Cardholder																													
Authorized Charge Amount \$																													
<i>I hereby authorize Academic HealthPlans to deduct the total amount due from my credit card.</i>																													
Signature of Cardholder																													
Date / /																													
Academic HealthPlans																													
Check Number																													
Check Amount																													
\$																													

I certify that I am currently participating in the insurance policy listed on the attached copy of my health insurance card and will continue to participate throughout the school year. I have compared the above policy with the student health insurance plan and have determined the benefits to be at least comparable. I further understand that by my submitting this enrollment form, I will still be responsible for my medical expenses and neither the college nor its health insurance program will be responsible for those expenses.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Student Signature (& Guardian's Signature if Student Is Under 18 Years of Age) *Date*

AH-29518