

SOUTHERN METHODIST UNIVERSITY
2011–2012 Student Health Insurance
Fall & Spring/Summer Enrollment Form for Domestic and International Student Dependents

474932-11

(Please Print)

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

List Dependents to be insured below. Dependent enrollment must take place at the initial time of student enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children. Dependent coverage is available only if the student is also insured. Dependent coverage cannot exceed the coverage of the Insured and expires concurrently with that of the Student.

	First Name	MI	Last Name	Date of Birth (M/D/Y)	Gender (M/F)	Social Security #
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

PLEASE CHECK ALL APPROPRIATE BOXES:

Academic Schools: Domestic International Arts Business Engineering Law Theology Other

Hours enrolled _____

Insured Type	Fall 08//13/11 through 01/09/12	Spring/Summer 01/10/12 through 08/12/12	<i>*If the student does not waive the insurance for the Fall and Spring Semester, the charges for the Student Only coverage will be automatically added to your tuition bill for the Fall and Spring Semester. If a student wants to enroll in this coverage, please go to www.smu.edu/healthinsurance for enrollment information. If you want to enroll your dependents, please complete this form and return to Academic HealthPlans. The premium must accompany the enrollment form.</i>
Student (tuition billed)*	\$ 759.00	\$ 759.00	
Spouse	\$ 1,933.00	\$ 1,933.00	
All Children	\$ 726.00	\$ 726.00	

PAYMENT INFORMATION					
Charge Full Amount		\$	Check Amount		\$
VISA	MasterCard	Discover	Check Number		#
Credit Card	#	Expiration Date		____ / ____	
			Month	Year	

I hereby authorize Academic HealthPlans to deduct the total premium due from my credit card.

SIGNATURE OF CARDHOLDER: _____ DATE _____

PRINTED NAME OF CARDHOLDER: _____ DATE _____

PREMIUM PAYMENT INSTRUCTIONS: Make check or money order payable to **Aetna Life Insurance Company** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605**. If you have questions, please call Academic HealthPlans at (888) 308-7320. Your canceled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the Effective Date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student and cardholder acknowledges the following: 1) Rates are not pro-rated other than as listed on this enrollment form; 2) Student meets the eligibility requirements for this coverage as described in the Brochure; 3) If it is later determined that the student is not Eligible, coverage will be deemed to have not been in force and the premium will be returned; and 4) Other than Eligibility or entry into the Armed Forces, the premium is not refundable. **It is the student's responsibility for timely renewal payments. This plan is underwritten by Aetna Life Insurance Company.**

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.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

Student's Signature: _____ Date _____

(Signature of Student or Parent if Student is under age 18)