University of Texas Health Science Center at San Antonio 2018 - 2019 Fall Scholar Health Insurance Enrollment Form

POSTDOCTORAL SCHOLARS AND THEIR DEPENDENTS

101464-18- Medical | 106145-18- Dental

(PLEASE PRINT CLEARLY or TYPE)

SCHOLAR INFORMATION									
Scholar Name	First		Middle Initial		Last				
Local & ID Card Mailing Address	Street or P.O.Box			City			State	Zip Code	
Permanent Address	Street or P.O.Box			City			State	Zip Code	
Email	*(A confirmation email will be sent upon enrollment)*			**Phone/Cell Number**		( ) —			
Male		**Female**		**Date of Birth**	(MM/DD/YYYY) / /	**SSN**	- -	**UT EID**	*(must be provided to be processed)*

LIST DEPENDENTS TO BE INSURED BELOW. Dependent coverage is available only if the scholar is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the scholar.

DEPENDENT INFORMATION						
Dependent	**First Name**	**MI**	**Last Name**	**Date of Birth (MM/DD/YYYY)**	**Gender (M/F)**	**Social Security Number**
Spouse				/ /		– –
Child 1				/ /		– –
Child 2				/ /		– –

NOTICE TO SCHOLAR. Coverage will be effective the date **of the Qualifying Event if required documentation and form are received within 31 days in which the Qualifying Event occurred,** unless otherwise stated in the Master Policy. By signing below, the scholar acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Scholar meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the scholar 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 scholar's responsibility to make a timely renewal payment. This plan is underwritten by **Blue Cross and Blue Shield of Texas**.

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

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

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.

SIGNATURE: _____ DATE: _____

(Signature of Scholar, or Parent if Scholar is under age 18)

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side. **CONTINUE ON REVERSE SIDE →**

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POSTDOCTORAL SCHOLARS AND THEIR DEPENDENTS

Scholar Name: _____ UT EID Number: _____
(must be provided to be processed)

The scholar and/or spouse MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage. The scholar and spouse must enroll in the same plan and coverage period.

*Optional Adult Dental coverage is only available to the scholar and spouse. Children that are under the age of 19 have pediatric dental benefits under the medical plan. The rate shown for children is the Medical Only rate. If you are a scholar that has turned 19, you are eligible to purchase the Adult Dental Plan by completing a Scholar Only Dental Qualifying Event Enrollment Form, available online at **uthscsa.myahpcare.com**.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

Scholar/Insured Classification: ☐ Post Doctorates 1 ☐ Post Doctorates 2

The monthly rate is to be used in the calculation of your total premium due only if the Covered Person has a qualifying event, such as marriage, birth, loss of coverage due to age limitation, etc. The monthly rate would be paid beginning in the month which the qualifying event occurred through the end of the current coverage period. **Note:** *If this enrollment is for a dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the scholar's existing coverage.*

PERIOD RATES AND COVERAGE DATES

MEDICAL + DENTAL COVERAGE DATES		MONTHLY RATE		CALCULATE TOTAL PREMIUM DUE
		Medical Only	Medical +Dental	Example: $209 x 3 months = $627
Fall	____/____/_____ through 12/31/2018			
Scholar		$ 209.00	$ 229.00	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
Spouse		$ 209.00	$ 229.00	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
Children *(Medical only)*		$ 334.00	$ 334.00*	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
			TOTAL	$

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). **It is the scholar's responsibility for timely renewal payment whether or not a renewal notice is received**. If you have questions, please call Academic HealthPlans at **1-855-247-7587**.

RENEWAL INFORMATION. You must take affirmative steps to enroll and pay for any spouse/dependent **each** semester if you want coverage for them. There will be no renewal notice sent at the end of the coverage period.

PAYMENT OPTIONS

If paying by credit card fax to **1-855-858-1964**		By check	
Amount to be charged	$	Make check or money order in U.S. dollars, payable to	Academic HealthPlans
Credit Card Number		Check Amount	$
Expiration Date	(MM/YY) /	Check Number	
Billing Zip Code		Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1805
VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐			

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. I understand my insurance will be cancelled if my credit card is declined. All charges will show on my credit card statement as Academic HealthPlans, Inc.**

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____