Aetna Life Insurance Company **Aetna Student Health**

Missouri University of Science & Technology
Visiting Scholar and Dependent Plan
2018/2019 Student Health Insurance Enrollment Form

In order to enroll you must complete steps 1 through 6!

1. Complete all Scholars information. Incomplete information will delay processing! Contact Aetna Student Health at 877-375-7905 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Visiting Scholar: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ ☐
Last Name First Name MI

Email address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐
This address will be used for Aetna Student Health insurance communications Apt.#

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ Zip Code: ☐☐☐☐☐

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐ Sex: ☐ Male ☐ Female
mm/dd/yy

Visiting Scholar ID: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. List Dependents to be insured. Dependent coverage is only available if the plan covers dependents, and the Scholar is covered.

Dependents	Last Name	First Name	DOB	Male/Female
Spouse				
Child				
Child				
Child				
Child				

3. Select Enrollment Plan

Coverage will begin on the day after payment is submitted. It is my responsibility to make timely payments. Eligible Visiting International Scholars and their eligible dependents that enroll in the school-sponsored scholar health insurance plan after the 15th of a given month will be charged for one-half of the monthly premium. NOTE: This option is available only in the first month of coverage based on the initial effective date. Full payment is due at the time of initial enrollment. The half monthly rate is only available to Scholar/Dependents that enter the U.S. after the 15th of the month. Coverage will be effective the day the Scholars/Dependent enters the U.S. Scholars/Dependents must enroll within 31 days of entering the US.

B1	*B2*	*B3*	*B4*	*B5*	*B6*	*B7*	*B8*	*B9*	*B10*	*B11*	*B12*
August 2018	**September 2018**	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**	**April 2019**	**May 2019**	**June 2019**	**July 2019**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

** Coverage will be effective from _____ to _____.
month/day/year month/day/year

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***** Coverage is only for the 2018/2019 academic year which is between 08/01/2018 and 07/31/2019.***

	½ Month Rate 890441-V21-1	Monthly Rate 890441-V21
Visiting Scholars	☐ **$78.50**	☐ **$157.00**
Spouse	☐ **$78.50**	☐ **$157.00**
Child(ren)	☐ **$78.50**	☐ **$157.00**

Number of Months Requested	X	Monthly Premium	=	TOTAL PREMIUM

PLEASE COMPLETE AND SIGN THE BACK 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. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!!

Charge full amount: $☐☐☐☐.☐☐

Credit Card#: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp. Date:** ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address (if different from Scholar):

It is the Scholars responsibility for timely renewal payments.

5. Notice to Scholars (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit Missouri University of Science & Technology to provide Aetna Student Health with 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 I am not eligible **(see the Plan Design and Benefits Summary for eligibility guidelines),** the premium will be refunded, minus any claims paid, but the premium is not refundable for reasons other than eligibility**.**

6. Do we have your permission to communicate electronically with you regarding this enrollment form and this Student and dependent Health Insurance Plan? Yes _____ No _____

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Enrollment Forms received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.**

Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Signature: _____ **Date**:_____

ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:

AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512

OR

FAX: 859-425-5200

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Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

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Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)