ahp | Academic HealthPlans

Send completed form, required documentation, and premium payment to:

Academic HealthPlans, Inc.
P O Box 1605
Colleyville, TX 76034-1605

ENROLLMENT BY QUALIFYING EVENT

This form must accompany the Academic HealthPlans enrollment form.

Student Name (Last, First, MI):	Social Security Number:
School Name:	Policy Number:

List Dependents to be Insured below.	Sex:	DOB: (MM/DD/YYYY)	Social Security Number:
Spouse (Last, First, MI):	M F	/ /	– –
Child (Last, First, MI):	M F	/ /	– –
Child (Last, First, MI):	M F	/ /	– –

Qualifying Event Date:	
Student Signature:	Date Signed:

Qualifying Event Information and Required Documentation:

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and this completed form. **Application for enrollment must be submitted within 31 days of the qualifying event. Improper documentation will result in a return of premium and a delay of coverage.**

	Qualifying Event *Please check the box below that is applicable to your situation. A box MUST be checked and the appropriate required documentation MUST accompany this form.*	**Documentation Required** *Letter of Ineligibility (lost coverage) is required for any reason listed.*
☐	Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause) Cause of Loss: _____ _____	Written documentation from the school or insurance company, on school/company letterhead, providing the names of the covered participants, date coverage ends and the reason for loss of eligibility
☐	Acquired a new dependent — spouse (and adding other previously eligible dependents)	Copy of marriage certificate
☐	Acquired a new dependent — newborn, adopted child, child arriving from another country (and adding other previously eligible dependents)	Copy of birth certificate for newborn; or proper visa documentation for child(ren) arriving from another country

FOR USE BY ACADEMIC HEALTHPLANS ONLY:		
Date Received:	Date Approved/Denied and Reason:	Effective Date:
Eligibility Representative Signature:		Date Signed:

BlueCross BlueShield of Texas

101468-15 - Medical | 106145-15 - Dental

THE UNIVERSITY OF TEXAS SYSTEM 2015-2016

SPRING QUALIFYING EVENT ENROLLMENT FORM

(PLEASE PRINT CLEARLY or TYPE)

Student's 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**	(Month/Day/Year) / /	**SSN**	- -	**UT EID**	*(Must be provided to be processed)*

List Dependents to be insured below. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

	First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security Number
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date **of the Qualifying Event if required documentation and form are received within 31 days of Qualifying Event**, 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 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 Student 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.

STUDENT'S SIGNATURE: _____ DATE: _____

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

CARDHOLDER'S SIGNATURE: _____ DATE: _____

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side.

BlueCross BlueShield of Texas

101468-15 - Medical | 106145-15 - Dental

THE UNIVERSITY OF TEXAS SYSTEM 2015-2016
SPRING QUALIFYING EVENT ENROLLMENT FORM

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

***Optional Adult Dental coverage is only available to the student 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 student that has turned 19, you are eligible to purchase the Adult Dental Plan by completing a Student Only Dental Qualifying Event Enrollment Form, available online at **utsystem.myahpcare.com**.*

Student Name: _____ **UT EID:** _____
(must be provided to be processed)

PLEASE CHECK ALL APPROPRIATE BOXES:

Campus	☐ UT Arlington	☐ UT El Paso	☐ UT MD Anderson	☐ UT Rio Grande Valley	☐ UT Tyler
	☐ UT Austin	☐ UT HSC Houston	☐ UT MB Galveston	☐ UT San Antonio	
	☐ UT Dallas	☐ UT HSC San Antonio	☐ UT Permian Basin	☐ UT Southwestern Medical Center	
Student/Insured Classification	☐ Undergraduate	☐ Graduate	☐ International	☐ Domestic	

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 dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the student's existing coverage.*

PERIOD RATES AND COVERAGE DATES:		
SPRING COVERAGE	**SPRING/SUMMER COVERAGE**	**SUMMER COVERAGE**
Visit utsystem.myahpcare.com and choose your campus to find the correct Premium Cost for the applicable coverage period.		

Insurance Coverage Dates Requested: ____/____/____ **through** ____/____/____

Coverage may not extend past the termination date of your campus policy year.

GAP RATE					**CALCULATE GAP RATE**
Coverage:	**Medical Only**		**Medical + Dental**		**Example: $182 x 3 months = $546**
Student	☐	$ 182.00	☐	$ 203.00	$____ (Rate) X ____ (# Months) = $____ (Total)
Spouse	☐	$ 512.00	☐	$ 533.00	$____ (Rate) X ____ (# Months) = $____ (Total)
Children	☐	$ 282.00	☐	$ 282.00* *(medical only)*	$____ (Rate) X ____ (# Months) = $____ (Total)
				Total Amount Due:	$

PAYMENT INFORMATION: Make check or money order payable to **Blue Cross and Blue Shield of Texas** 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, or fax to (817) 809-4701 if paying by credit card.** If you have questions, please call Academic HealthPlans at (855) 247-7587. Your cancelled 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.**

PAYMENT OPTIONS									
☐	**Charge Full Amount via Card**	$					☐	**Check made payable to**	***Blue Cross and Blue Shield of Texas***
☐	VISA	☐	MasterCard	☐	Discover	Expiration Date	____/____ (Month / Year)	Check Amount	$
Credit Card Number								Check Number	

❑ **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 _____