Aetna Life Insurance Company **Aetna Student Health, An Aetna Company**
Claims Administrator

University at Buffalo– MEDICAL/DENTAL Student and Dependent Insurance Plan
2009/2010 Student Health Insurance Enrollment Form

In order to enroll you must complete steps 1 through 5!

If you are not a Medical or Dental Student: There is a separate application for you or dependents.

1. Complete all Student information. Incomplete information will delay processing!

Contact The AETNA Group at 800-954-5793 or SMI 716-645-3036 for assistance.

Student Name: _____ _____ _____
Last Name First Name MI

Student ID #:: _____ Email address: _____

Mailing Address: _____ Apt.#: _____
This address will be used for all **AETNA STUDENT HEALTH** insurance communications

City: _____ State:_____ Zip Code: _____ Phone Number: ( )_____- _____

Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___ Sex: □ Male □ Female

2. Select Enrollment Plan

Form ID: 100116-10	A.	C.	D.	Cert. Credible Coverage □
Basic Plan	Annual Effective Date: Aug. 22, 2009 - Aug. 21, 2010 Deadline: 10/7/2009	Spring/Summer Effective Date: Jan. 09, 2010 - Aug. 21, 2010 Deadline: 2/17/2010	Summer Effective Date: May 16, 2010 - Aug. 21, 2010 Deadline: 6/1/2010	Off Cycle Effective Date: ___/___/___ - Aug. 21, 2010 Deadline: w/I 31 days
1.Student	□ BB - $1,763	□BB - $ 1,035	□ BB - $451	□ BB - $
2. Spouse	□ BB - $3,946	□ BB - $2,308	□ BB - $997	□ BB - $
3. Child	□ BB - $3,072	□ BB - $1,798	□ BB - $779	□ BB - $
Total				

3. List Dependents to be insured. Dependent coverage is only available if the student is covered.

Dependents	Last Name	First Name	Date Of Birth	Notes	M/F
Spouse					M F
Child					M F
Child					M F
Child					M F
Child					M F

PLEASE COMPLETE AND SIGN THIS FORM. APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

4. Designate Payment Method: The premium will be added to your Bursar Bill. Students on Leave, Post Doc/Bach are required to pay by check or money order made payable to Sub Board One, Inc.

5. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit UB to provide The Aetna Group 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 brochure, pamphlet or Master Policy for eligibility guidelines),** the premium will be refunded, but the premium is not refundable for reasons other than eligibility**. It is the student's responsibility for timely renewal payments.**

***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. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. Application to enroll late in the plan must be made within 31 days of loss of other coverage. A letter of creditable coverage from the prior insurance carrier must accompany the application.**

Signature:_____**Date**:_____

MAIL TO:
SBI Student Medical Insurance Office, 223 Student Union, Box 602100, Buffalo, NY 14260-2100, 716-645-3036