OKLAHOMA CHRISTIAN UNIVERSITY **000501-12**

2012–2013 Dependent Health Insurance Enrollment Form

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 *(A confirmation email will be sent to your email address.)*			**Cell or Telephone Number** ( ) —					
Male		**Female**		**Date of Birth** (Month/Day/Year) / /	**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:

Student/Insured Classification: ❑ Undergraduate ❑ Graduate Hours enrolled _____

Basic Coverage		**Annual 08/12/12 thru 08/11/13**		**Fall* 08/12/12 thru 01/09/13**		**Spring/Summer 01/10/13 thru 08/11/13**		**Summer 05/01/13 thru 08/11/13**
Student *(Tuition Billed)*		$ 1,063.00		$ 469.00		$ 680.00		$ 324.00
Spouse		$ 2,166.00		$ 942.00		$ 1,361.00		$ 660.00
All Children		$ 1,633.00		$ 695.00		$ 1,025.00		$ 499.00

*ONLY Seniors graduating in December are eligible to purchase the Fall coverage.

(Charges include a $15 administration fee by coverage period for each enrollee to be retained by the University.)

Payment Instructions: Make check or money order payable to **Oklahoma Christian University** in U.S. dollars. Mail or Return this enrollment form along with payment to the **Student Counseling Center, PO Box 11000, Oklahoma City, OK 73136-1100**. If you have questions, please call Academic HealthPlans at (855) 247-2273. 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: Coverage will be effective the date the correct payment 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 acknowledges the following: **1)** Charges are not pro-rated other than as listed on this enrollment form; **2)** He/She 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 payment will be returned; and **4)** Other than Eligibility or entry into the Armed Forces, the payment is not refundable. It is the student's responsibility for timely renewal payments. **This plan is underwritten by Blue Cross And Blue Shield of Oklahoma Insurance Company.**

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)

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