OKLAHOMA CHRISTIAN UNIVERSITY
2012–2013 Student Dental Enrollment Form

Blue Cross and Blue Shield of Oklahoma
K00014-12

Please complete the form below or enroll online at www.ahpcare.com/oc.

Dental coverage is available to students and dependents. Students are NOT required to be enrolled in the Student Health Insurance Plan to be eligible to enroll in the Dental coverage. If the student chooses to purchase dental coverage for the dependent, it must be purchased at the same time as the student coverage. The dependent must have the same coverage as the student. Students and dependents may enroll online for dental coverage or download the dental enrollment form at www.ahpcare.com/oc, complete the form and mail it along with premium to Academic HealthPlans.

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 upon enrollment.)*			**Cell or Telephone Number** ( ) —				
Male		**Female**		**Date of Birth** (Month/Day/Year) / /	**SSN** - -	**Student 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: **Hours enrolled** _____

Student/Insured Classification: ❑ Domestic ❑ International

PERIOD RATES AND COVERAGE DATES:

		Annual 08/12/12 through 08/11/13		Spring/Summer 01/10/13 through 08/11/13
Student		$ 146.52		$ 86.44
Student & Spouse		$ 283.32		$ 167.16
Student & All Children		$ 271.80		$ 160.36
Student, Spouse & Children		$ 408.60		$ 241.08

Premium Payment Instructions: Make check or money order payable to **Blue Cross and Blue Shield of Oklahoma** 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**. 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.**

PAYMENT INFORMATION							
Charge Full Amount	$					Check Amount	$
	VISA		MasterCard		Discover	Check Number	
Credit Card #						Expiration Date	____/____ Month Year

❑ **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 _____

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date the correct premium 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 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 for timely renewal payments. This plan is underwritten by Blue Cross Blue and Shield of Oklahoma.

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)