UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON **Blue Cross and Blue Shield of Texas**

2012–2013 STUDENT HEALTH INSURANCE ENROLLMENT FORM **101504-12**

ACADEMIC STUDENTS

Please complete this form below.

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 this address.)*			**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				/ /		— —
Child				/ /		— —

NOTICE TO STUDENT AND CARDHOLDER: 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 and cardholder acknowledges the following: **1)** Charges 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 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 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 _____

12-EF

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ACADEMIC STUDENTS

Please make your selection carefully; you cannot change your coverage after the initial purchase of the Plan.

Attention Students Only:** Plan 1 will be billed to your student account. If you choose to upgrade to Plan 2 with a $500,000 maximum at the initial time of enrollment, you must submit payment for Plan 2 directly to Academic HealthPlans by September 27, 2012.* ***If purchasing Dependent coverage, the dependent's coverage period must coincide and cannot exceed the coverage period purchased by the student.

PLEASE CHECK ALL APPROPRIATE BOXES:

Annual 08/27/12 through 08/26/13	Plan 1 $100,000 Maximum	Plan 2 $500,000 Maximum
Student *(Plan 1 only tuition billed)*	$ 1,204.00	$ 648.00
Spouse	$ 3,506.00	$ 4,154.00
All Children	$ 1,894.00	$ 2,542.00

Spring 01/14/13 through 05/19/13	Plan 1 $100,000 Maximum	Plan 2 $500,000 Maximum
Student *(Plan 1 only tuition billed)*	$ 416.00	$ 224.00
Spouse	$ 1,210.00	$ 1,434.00
All Children	$ 654.00	$ 878.00

Quarterly* (Select Quarter Below)	Plan 1 $100,000 Maximum	Plan 2 $500,000 Maximum
Student *(Plan 1 only tuition billed)*	$ 301.00	$ 162.00
Spouse	$ 877.00	$ 1,039.00
All Children	$ 474.00	$ 636.00

Summer 05/20/13 through 08/26/13	Plan 1 $100,000 Maximum	Plan 2 $500,000 Maximum
Student *(Plan 1 only tuition billed)*	$ 333.00	$ 179.00
Spouse	$ 970.00	$ 1,149.00
All Children	$ 524.00	$ 703.00

Fall 08/27/12 through 01/13/13	Plan 1 $100,000 Maximum	Plan 2 $500,000 Maximum
Student *(Plan 1 only tuition billed)*	$ 455.00	$ 245.00
Spouse	$ 1,326.00	$ 1,571.00
All Children	$ 716.00	$ 961.00

***Quarterly Coverage Periods:** ❑08/27/12 through 11/26/12 ❑11/27/12 through 02/26/13 ❑02/27/13 through 05/26/13 ❑05/27/13 through 08/26/13*

PAYMENT OPTIONS:

Mail payment directly to Company. 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 payment to Visa, MasterCard, or Discover Card. Mail this enrollment form along with payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605.** Your cancelled check or credit card billing is your only receipt and notification of coverage. Notices will be mailed if paying by installments. However, **it is the student's responsibility for timely payment whether or not a notice is received.**

PAYMENT INFORMATION									
Charge Full Amount	$						Check Amount	$	
	VISA		MasterCard		Discover		Check Number		
Credit Card Number							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.**

SIGNATURE OF CARDHOLDER: _____ DATE _____