Drexel University
Visiting Student – Student and Dependent Student Health Enrollment Form

Aetna Life Insurance Company

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you. That can delay its processing. You are responsible for its accuracy and completeness. Contact Aetna Student Health at 877-480-4161 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected. When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.

A. Student information – ***You must complete this section.***

First name: Priontu		Middle initial:	Gender (Male/Female/ Nonbinary): Male
Last name: Chowdhury			
Local US Address: 115 N 32nd St, Philadelphia, PA			Apt.
City: Philadelphia		State: Pennsylvania	ZIP code: 19104
Email address: priontuchowdhury@gmail.com			
Phone Number: (+49) 175 - 4425136	Date of Birth: 08/21/1996 (mm/dd/yy)	Student ID Number: 14601785	

Do we have your permission to communicate electronically with you regarding this enrollment form and this Student and dependent Health Insurance Plan? Yes ✓ No _____

Dependents	Last Name	First Name	DOB	Male/Female/Nonbinary
Spouse Domestic Partner, Civil Union				
Child				
Child				
Child				
Child				

D. Designate Payment Method

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY

Charge full amount: $_____.__

Credit Card#: _____

Exp. Date: ___/___ (MM/YY) **Security Code*:___** (*three-digit code back of card/Amex-4 digit on front of card)

Signature of Cardholder:_____

Name as it appears on Card:_____

Billing Information:

Street: _____

City: _____

State: _____ **Zip Code:**_____

Phone Number:_____

WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION WITHOUT YOUR SIGNATURE.

CHECKING ACCOUNT -PLEASE PRINT CLEARLY

Charge full amount: $_____.__

Bank Name:_____

Routing number#: _____

Checking Account #:_____

Billing Information

Street: _____

City:_____

State:_____ **Zip Code:**_____

Phone Number:_____

WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION WITHOUT YOUR SIGNATURE.

E. Notice to Student

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten and administered by Aetna Life Insurance Company.

1. My school the policyholder determines coverage options. I don't have coverage until Aetna approves my enrollment form and the policyholder's application. Even if Aetna approves the [policyholder's] application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

2. I authorize the Aetna companies underwriting and/or administering the coverages checked above to use and disclose the minimally necessary information about medical history, services or treatment provided to anyone listed on this form to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities

   This may include minimally necessary information about mental health, substance use disorder and Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS.)

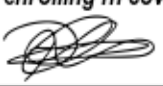
I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I or my authorized representative am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.

3. I understand that
   - The Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. Aetna cannot guarantee the availability of any particular provider. Any provider network is subject to change. Aetna will provide a notice of the change in accordance with applicable state law.

4. I understand that, with certain exceptions described in the plan documents, DMO© plans only provide coverage for services from participating dental care providers. The plan documents also describe if I need a referral for certain procedures, and who can provide care. I authorize the substitution of generic drugs for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete. I agree to the conditions of enrollment and the misrepresentation statement on this Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

Misrepresentation: Any person who knowingly and with intent to deceive or defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Please sign here ONLY if you are enrolling in coverage for yourself and /or dependents.	***Date (Month/Day/Year)***
Student signature (required)  **X**	19/08/2022

ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:

Fax Application to : 860-907-4672
Attention: Allie Williams

Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.
Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English. These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.
If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement
Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish
Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ/**Amharic**
ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية/**Arabic**
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wù ɖù/**Bassa**
Dɛ̀ dɛ nìà kɛ dyɛ́ɖɛ́ gbo: Ɔ jʊ̌ kɛ́ m̀ dyi Bàsɔ́ɔ́-wù ɖù-po-nyɔ̀ jʊ̌ nǐ, nìǐ à wu ɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɓa **1-877-480-4161** (TTY: **711**).

中文/**Chinese**
注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/**Farsi**
توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.