ahp | Academic HealthPlans

101464-19- Medical | 106145-19- Dental

The University of Texas System 2019 - 2020 Scholar Health Insurance Enrollment Form

VISITING SCHOLARS AND THEIR DEPENDENTS

(PLEASE PRINT CLEARLY or TYPE)

SCHOLAR INFORMATION									
Scholar Name	First		Middle Initial		Last				
Local & ID Card 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)*			**Phone/Cell Number**		( ) —			
Male		**Female**		**Date of Birth**	(MM/DD/YYYY) / /	**SSN**	- -	**UT EID**	*(must be provided to be processed)*

List Dependents to be insured below. Dependent enrollment must take place at the time of scholar enrollment, with the exception of newborn or adopted children or a qualifying event. Dependent coverage is available only if the scholar is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the scholar.

Dependent	First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security Number
Spouse				/ /		— —
Child 1				/ /		— —
Child 2				/ /		— —

ENROLLMENT TERMS & CONDITIONS: 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 Scholar and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Scholar meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the Scholar is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and **4)** Other than entry into the Armed Forces, **the premium is not refundable**. It is the Scholar's responsibility to make a timely renewal payment. 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.

SIGNATURE: _____ DATE: _____

(Signature of Scholar, or Parent if Scholar is under age 18)

Please note this enrollment form cannot be processed unless you make all your coverage selections on the next page. **CONTINUE ON NEXT PAGE →**

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101464-19- Medical | 106145-19- Dental

Scholar Name: _____ UT EID Number: _____

(must be provided to be processed)

The scholar MUST be enrolled in the medical coverage to be eligible to enroll in the optional adult dental coverage. The Scholar and spouse must enroll in the same plan and coverage period.

[1]**Optional Adult Dental coverage is only available to the Scholar and spouse.** Children that are under the age of 19 have pediatric dental benefits under the medical plan. The rate shown for children is the Medical Only rate. If you are a Scholar that has turned 19, you are eligible to purchase the Adult Dental Plan by completing a Scholar Only Dental Qualifying Event Enrollment Form, available online at **utsystem.myahpcare.com**.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

CAMPUS	☐	**UT Arlington**	☐	**UT El Paso**	☐	**UT MD Anderson**	☐ **UT Rio Grande Valley School of Medicine**
	☐	**UT Austin**	☐	**UT HSC Houston**	☐	**UT MB Galveston**	☐ **UT San Antonio**
	☐	**UT Austin Dell Medical School**	☐	**UT HSC San Antonio**	☐	**UT Permian Basin**	☐ **UT Southwestern Medical Center**
	☐	**UT Dallas**	☐	**UT HSC Tyler**	☐	**UT Rio Grande Valley**	☐ **UT Tyler**

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES

****Coverage Dates**
____/____/_____
through
____/____/_____

****Coverage may not extend past the termination date of your campus policy year**

MONTHLY RATE

Coverage	Medical Only	Medical + Dental Only	*CALCULATE TOTAL PREMIUM DUE Example: $232.50 x 3 months = $697.50
Scholar	☐ $ 232.50	☐ $ 253.50	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
Spouse	☐ $ 232.50	☐ $ 253.50	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
Children *(Medical only)*	☐ $ 373.00	☐ $ 373.00[1]	$ _____ (Rate) X _____ (# Months) = $ _____ (Total)
		TOTAL	$

Visit utsystem.myahpcare.com and choose your campus to find the correct Premium Cost for the applicable coverage period.

***TOTAL PREMIUM MUST BE PAID IN FULL**

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). **It is the Scholar's responsibility for timely renewal payment whether or not a renewal notice is received**. If you have questions, please call Academic HealthPlans at **1-855-247-7587**.

RENEWAL INFORMATION. You must take affirmative steps to enroll and pay for any spouse/dependent **each** semester if you want coverage for them. There will be no renewal notice sent at the end of the coverage period.

PAYMENT OPTIONS

If paying by credit card fax to **1-855-858-1964**		By check	
Amount to be charged	$	Make check or money order in U.S. dollars, payable to	Academic HealthPlans
Credit Card Number		Check Amount	$
Expiration Date	(MM/YY) /	Check Number	
Billing Zip Code		Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐			

☐ **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: _____