ahp | Academic HealthPlans

25-85558-18
Effective Date of Coverage: 08/01/2018

# Clemson University 2018 - 2019
# 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** | - - | **Scholar ID Number** | *(must be provided to be processed)* |

**LIST DEPENDENTS TO BE INSURED BELOW**. 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 INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| **Dependent** | **First Name** | **MI** | **Last Name** | **Date of Birth** (MM/DD/YYYY) | **Gender** (M/F) | **Social Security Number** |
| **Spouse** | | | | / / | | — — |
| **Child 1** | | | | / / | | — — |
| **Child 2** | | | | / / | | — — |
| **Child 3** | | | | / / | | — — |

**NOTICE TO SCHOLAR.** 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 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 eligibility or 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 South Carolina**.

**I understand my information is protected by privacy laws and will be released only in accordance with these laws.**

**My signature below represents that I have read and understand the Scholar 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/Guardian 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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## VISITING SCHOLARS AND THEIR DEPENDENTS

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Effective Date of Coverage: 08/01/2018

Scholar Name: _____ Scholar ID Number: _____
(must be provided to be processed)

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

**Note:** *If this enrollment is for a dependent only, the dependent is allowed to purchase only the number of months that will allow them to reach the termination date of the scholar's existing coverage.*

**PERIOD RATES AND COVERAGE DATES**

| COVERAGE DATES | MONTHLY RATE | | CALCULATE TOTAL PREMIUM DUE |
|---|---|---|---|
| | Coverage | Monthly Rate | Example: $171.50 x 3 months = $514.50 |
| Requested Dates<br>____/____/_____<br>through<br>____/____/_____ | Scholar | $ 171.50 | $171.50 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Spouse | $ 171.50 | $171.50 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Each Child | $ 171.50 | $171.50 (Rate) X _____ (# Months) = $ _____ (Total) |
| | Three or More Children | $ 514.50 | $514.50 (Rate) X _____ (# Months) = $ _____ (Total) |
| | | TOTAL | $ |
| Coverage may not extend past the termination date 07/31/2019 | | | |

The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments. Please use the chart above to calculate total amount due.

**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 **1-855-856-2384**.

**RENEWAL INFORMATION**. You must take affirmative steps to enroll and pay for yourself each semester if you want coverage. 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<br>P.O. Box 1605<br>Colleyville, TX 76034-1805 |
| VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐ | | | |

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of premium. I understand the insurance will be cancelled if the 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: _____