Indiana University School of Medicine
2009-2010 Dependent Enrollment Form for Post Doctoral Fellows

(Dependents of Medical Students should not complete this application.)

In order to enroll you must complete steps 1 through 5

1. Complete all Student/Post-Doc information. Incomplete information will delay processing

Student/Post-Doc Name: _____
Last Name First Name MI

Social Security Number: _____ Email Address: _____

Mailing Address: _____
Apt. #

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female
mm/dd/yy

2. *List Dependents to be insured. Dependent coverage is only available if the Student/Post-Doc is covered.*

Dependents	Last Name	First Name	DOB	Social Security Number	M/F
Spouse/Same Sex Domestic Partner					
Child					
Child					
Child					

3. Please select the correct Enrollment Period .

812801-D12-1	A	B	C
Dependents of Post Doctoral Fellows	**Annual 07/01/09-06/30/10 Deadline: 09/01/09**	**Fall Only 07/01/09-12/31/09 Deadline: 09/01/09**	**Spring Only 01/01/10-06/30/10 Deadline: 02/27/10**
2. Spouse/Same Sex Domestic Partner	☐ **$4,437**	☐ **$2,219**	☐ **$2,219**
3. Child(ren)	☐ **$2,358**	☐ **$1,179**	☐ **$1,179**

***Domestic Partner Form Enclosed? YES NO**

To obtain a form or get more information regarding "domestic partner," please contact Aetna Student Health at 800-239-9691.

4. *Designate Payment Method.*

Make check or money order payable to Aetna Student Health or refer to the charge card authorization to charge premium to Visa or MasterCard (Please note Visa and MasterCard are the only credit cards accepted). CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)

Charge full amount: $☐☐☐☐.☐☐

Credit card# (Visa or MasterCard only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp. Date:** ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address(if different from Student/Post-Doc):

5. Notice to Student/Post Doc (Signature required)

Please enroll my eligible dependents in the plan(s) I have indicated above. I understand that to enroll my dependents in the Student Health Insurance Plan, I must also be enrolled in the Student Health Insurance Plan.

I have carefully read the brochure and elect to enroll as indicated. Rates are not prorated other than as listed. I permit Indiana University School of Medicine to provide Aetna Student Health with my enrollment status for purpose of eligibility under this Plan. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage and my dependent(s) coverage can be made void. I understand that if it is later determined that the Post-Doc is not eligible, the premium will be refunded, unless a claim has been filed, but the premium is not refundable for reasons other than eligibility.
Enrollment Guidelines: Applications will not be accepted after the deadline unless there is a significant life change that directly affects his or her insurance coverage. When applying after the deadline due to a life event please attach the appropriate documentation.

Signature: _____Date: _____

MAIL TO: Aetna Student Health, P.O. Box 15706, Boston, MA 02215-0014