Indiana University
Student Academic Appointees and Fellowship Recipients
2009-2010 PPO Dental Dependent Enrollment Form

In order to enroll you must complete steps 1 through 6!

1. *Plan Option*

Policy Number: **812849** Plan Option: ☐Dental PPO

2. *Complete all Student information. Incomplete information will delay processing.*

Student Name: ____
Last Name First Name MI

Social Security#: _______________ _______________ Email Address: ______________________

Mailing Address: ____
Apt. #

City: ____________________________________ State: _________ Zip Code: _______________

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

3. *List Dependents to be insured. Dependent coverage is only available if the student is covered.*

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

4. *Select Enrollment Period. Dependents must enroll in the same plan as the student.*

812849-PPO12-1	**Annual Rate** **Effective Date 08/15/2009-08/14/2010** **Deadline Date 09/15/2009**	**Fall Rate** **Effective Date 08/15/2009-12/31/2009** **Deadline Date 09/15/2009**	**Spring Rate** **Effective Date 01/1/2010-08/14/2010** **Deadline Date 01/31/2010**
Spouse/Same Sex Domestic Partner*	☐$295.92	☐$112.45	☐$183.47
Child(ren)	☐$443.88	☐$168.67	☐$275.21

***Please note: If you are enrolling your same-sex domestic partner, please contact the Campus Student Insurance Coordinator at (812) 856-4650 to complete the domestic partner statement.**

5. *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). <u>CASH WILL NOT BE ACCEPTED.</u>

<u>CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!! (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)</u>

Charge full amount: $☐☐☐☐.☐☐

Credit Card# (Visa or MasterCard only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date: ☐☐/☐☐

Signature of Cardholder:____

Printed Name and Address (Please Note: If this information is different from the student it must be included or the application will be rejected.):

PLEASE READ AND SIGN THE BACK OF THIS FORM. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →

6. Notice to Student (Signature required)

On behalf of myself and the dependents listed on the previous page, I agree to or with the following:

1. To enroll, complete the enrollment form and remit the appropriate premium prior to the deadline date. Applications and premium received after the stated deadline date will not be accepted and premium will be refunded. The period of coverage must be selected, and the applicable premium must be paid, at the time of enrollment. There is no renewable option and no refunds are available.
2. I acknowledge that by enrolling in an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my institution or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on the Enrollment/Change Request form. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of this coverage and so long thereafter as allows by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. NOTICE: Aetna does not request information for genetic testing and does not subject insured to genetic testing.
5. The plan documents will determine the rights and responsibilities of member(s) ad will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
6. I understand and agree that all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Signature: ____ **Date:** ____________________

MAIL TO: AETNA STUDENT HEALTH P.O. BOX 15706, BOSTON, MA 02215-0014