

Indiana University SAA & Fellowship Recipients 2009-2010 Dependent Enrollment Form

(PLEASE COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM)

All information must be complete and the appropriate premium received by the deadlines listed below in order to process your application.

ELIGIBILITY TO PARTICIPATE IN THIS PLAN:

- **Spouse and/or dependent children** may be enrolled in the Plan only if the student is also insured by the IU SAA/Fellowship Recipient Student Insurance Plan. Spouse must be residing with the insured and dependent children must be unmarried, under 24 years of age, not self-supporting, and residing with the insured.

Enrollment Deadlines

Enrollment applications must be received by Aetna Student Health no later than the dates indicated below. If the deadline has passed, you may enroll for coverage beginning with the next coverage period, provided an application and appropriate premium have been received by Aetna Student Health prior to or on the established deadline.

Enrollment Period	Deadline
Annual-/Fall, 2009	September 15, 2009
Spring/Summer, 2010	January 31, 2010
Quarterly, 2009-2010*	September 15, 2009*

*If a quarterly payment is missed the dependent(s) will not be able to enroll until the next open enrollment period and a break in coverage will apply. The 2nd quarter deadline is 11/16/09. The 3rd quarter deadline is 2/15/10 and the 4th quarter deadline is 5/14/10.

Enrollment after the deadlines specified above is allowed only for the loss of other health insurance coverage, marriage or the birth/adoption of a child. You must contact Aetna Student Health *within 31 days of losing other coverage, marriage, or birth/adoption of a child.*

(PLEASE PRINT)

Step One: Provide Student/Dependent Information

Student's Name: _____ Indiana University Student ID#: _____
Last First MI

Permanent
 U.S. Address: Street or P. O. Box: _____ City: _____ State: _____ Zip Code: _____

Phone Number (____) _____ Date of Birth: ____/____/____ Male Female E-Mail Address: _____
mm/dd/yy

List Dependents to be insured below. Dependent Coverage is available using this enrollment form only if the student is also insured under this Plan.

<u>Last Name</u>	<u>First Name</u>	<u>M.I.</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Social Security No.</u>	<u>Gender</u>
_____	_____	_____	Spouse/Same Sex Domestic Partner*	____/____/____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	____/____/____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	____/____/____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	Child	____/____/____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F

***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.**

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Step Two: Select Appropriate Enrollment Period and Rates

Basic Plan	Annual A 8/15/09-8/14/10	Quarterly* B 8/15/09-11/14/09 11/15/09-2/14/10 2/15/10-5/14/10 5/15/10-8/14/10	Fall C 8/15/09-12/31/09	Spring/Summer D 1/01/10-8/14/10
1. Spouse/ Same Sex Domestic Partner*	<input type="checkbox"/> \$4,370	<input type="checkbox"/> \$1,093*	<input type="checkbox"/> \$1,665	<input type="checkbox"/> \$2,704
2. Child(ren)	<input type="checkbox"/> \$3,316	<input type="checkbox"/> \$829*	<input type="checkbox"/> \$1,255	<input type="checkbox"/> \$2,060

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

