

WESTERN KENTUCKY UNIVERSITY
Domestic and International Health Insurance Enrollment Form - Student, Spouse and Dependents
2009 - 2010

SDHN01063601-09

Please complete form below or enroll online at: www.AHPCare.com/wku

International students may complete this form ONLY for enrolling spouse and children or if payment for student was NOT included in tuition bill.

Student's Name: _____
 First/Given Middle Initial Last/Family

Local Mailing Address: _____
 Street or PO Box City State Zip Code

Permanent Address: _____
 Street or PO Box City State Zip Code

Email _____ Telephone Number _____ - _____ - _____
 (A confirmation email will be sent upon enrollment.)

Date of Birth ____/____/____ Male ____ Female Cell Number _____ - _____ - _____
 Month Day Year

Student I.D. _____ SSN _____ - _____ - _____

List Dependents to be insured below. Dependent enrollment must take place at the initial time of student enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children. Dependent coverage is available only if the student is also insured. Dependent coverage cannot exceed the coverage of the Insured and expires concurrently with that of the Student.

	First/Given Name	MI	Last/Family Name	Date of Birth (Month/Day/Year)	Gender (M/F)	Social Security #
Spouse	_____	_____	_____	_____	_____	____-____-____
Child	_____	_____	_____	_____	_____	____-____-____
Child	_____	_____	_____	_____	_____	____-____-____

PLEASE CHECK ALL APPROPRIATE BOXES:

Student Classification: Graduate Undergraduate Domestic International Hours Enrolled _____

	Annual 08/01/09 to 08/01/10	Fall 08/01/09 to 01/15/10	Spring/Summer 01/15/10 to 08/01/10	Summer 05/01/10 to 08/01/10
Student*	<input type="checkbox"/> \$ 994.00	<input type="checkbox"/> \$ 497.00	<input type="checkbox"/> \$ 497.00	<input type="checkbox"/> \$ 260.00
Spouse	<input type="checkbox"/> \$2,923.00	<input type="checkbox"/> \$1,490.00	<input type="checkbox"/> \$1,490.00	<input type="checkbox"/> \$ 753.00
Each Child	<input type="checkbox"/> \$2,143.00	<input type="checkbox"/> \$1,094.00	<input type="checkbox"/> \$1,094.00	<input type="checkbox"/> \$ 552.00

*Administrative fee is included in the charges above.

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ CHECK # _____

VISA
 MASTERCARD
 DISCOVER CHECK AMOUNT \$ _____

CREDIT CARD # _____ - _____ - _____ Expiration Date _____
 Month / Year

CREDIT CARD BILLING ADDRESS: _____
 Street or PO Box City State Zip Code

I HEREBY AUTHORIZE ACADEMIC HEALTHPLANS TO DEDUCT THE TOTAL PREMIUM DUE FROM MY CREDIT CARD.

SIGNATURE OF CARDHOLDER: _____ DATE _____

PRINTED NAME OF CARDHOLDER: _____ DATE _____

PAYMENT INSTRUCTIONS: Make check or money order payable to **ACE American Insurance Company** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605**. If you have questions, please call Academic HealthPlans at (888) 308-7320. Your canceled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**

NOTICE TO STUDENT: Coverage will be effective the date the correct payment 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 student acknowledges the following: 1) Charges are not pro-rated other than as listed on this enrollment form; 2) He/She meets the eligibility requirements for this coverage as described in the Brochure; 3) If it is later determined that the student is not Eligible, coverage will be deemed to have not been in force and the payment will be returned; and 4) Other than Eligibility or entry into the Armed Forces, the payment is not refundable. It is the student's responsibility for timely renewal payments. This plan is underwritten by ACE American Insurance Company.

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.

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.

Student's Signature: _____ Date _____

(Signature of Student or Parent if Student is under age 18)