

SAM HOUSTON STATE UNIVERSITY
2011–2012 Student Health Insurance Plan
Domestic Student Insurance Enrollment Form

SDHN01063455-11

Student's Name		First	Middle Initial	Last	
Mailing Address		Street or P.O.Box		City	State Zip Code
Permanent Address		Street or P.O.Box		City	State Zip Code
Email <small>(A confirmation email will be sent upon enrollment)</small>				Cell or Telephone Number () —	
Male	Female	Date of Birth <small>(Month/Day/Year)</small>	School ID #		

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 Name	MI	Last Name	Date of Birth (M/D/Y)	Gender (M/F)	Social Security #
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

PLEASE CHECK ALL APPROPRIATE BOXES:

Student/Insured Classification: Undergraduate Graduate Hours enrolled _____

	Annual 08/15/11 through 08/14/12	Fall 08/15/11 through 12/31/11	Spring/Summer 01/01/12 through 08/14/12	Summer 05/30/12 through 08/14/12
Student	\$ 798.00	\$ 323.00	\$ 525.00	\$ 202.00
Spouse	\$ 1,844.00	\$ 751.00	\$ 1,222.00	\$ 471.00
Each Child	\$ 922.00	\$ 378.00	\$ 614.00	\$ 237.00

*Optional Club Sports Additional Premium	*Optional Major Medical
Student ONLY	Student ONLY
\$ 128.00	\$ 245.00

*Optional coverage may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the Plan. Only those students enrolled in Basic coverage may purchase Optional coverage.

DEPENDENT PAYMENT INFORMATION

Premium 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 premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605**. If you have questions, please call Academic HealthPlans at (855) 247-2273. 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.**

PAYMENT INFORMATION			
Charge Full Amount		\$	Check Amount \$
VISA	MasterCard	Discover	Check Number
Credit Card #		Expiration Date	
		____/____/____ Month / Year	

I hereby authorize Academic HealthPlans to deduct the total premium due from my credit card.

SIGNATURE OF CARDHOLDER: _____ DATE _____

PRINTED NAME OF CARDHOLDER: _____ DATE _____

NOTICE TO STUDENT AND CARDHOLDER: 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 student and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Student 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 premium will be returned; and **4)** Other than Eligibility or entry into the Armed Forces, the premium is not refundable. It is the student's responsibility for timely renewal payments. This plan is underwritten by **ACE American Insurance Company**.

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

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.

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.

Student's Signature: _____ Date _____

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