BAYLOR UNIVERSITY
2011–2012 J-1 Scholar Insurance Enrollment Form

Blue Cross and Blue Shield of Texas
Policy #: 078152-11 - Medical
078153-11 - Dental

Please complete form below.

J-1 Scholar's Name	First	Middle Initial	Last		
ID Card Mailing Address	Street or P.O.Box	City		State	Zip Code
Permanent Address	Street or P.O.Box	City		State	Zip Code
(A confirmation email will be sent upon enrollment) **Email**		**Cell or Telephone Number** ( ) —			
Male	**Female**	**Date of Birth** (Month/Day/Year) / /	**SSN** - -	**Scholar ID #**	

List Dependents to be insured below. Dependent enrollment must take place at the initial time of **J-1** scholar enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children. Dependent coverage is available only if the **J-1** scholar is also insured. Dependent coverage cannot exceed the coverage of the Insured and expires concurrently with that of the **J-1** scholar.

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

NOTICE TO J-1 SCHOLAR 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 **J-1** scholar and cardholder acknowledges the following: 1) Rates are not pro-rated other than as listed on this enrollment form; 2) **J-1** Scholar meets the eligibility requirements for this coverage as described in the Brochure; 3) If it is later determined that the **J-1** scholar 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 scholar's responsibility for timely renewal payments. This plan is underwritten by Blue Cross and Blue Shield of Texas.

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 ~~J-1 Scholar insurance plan~~ 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.

Scholar's Signature: _____ Date _____

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

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side.

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PLEASE CHECK ALL APPROPRIATE BOXES:

Do you have other Insurance: ❑ **Yes** ❑ **No**

If yes, Insurance Company Name:_____ **Policy Number:**_____

Medical Only **Policy #: 078152**		**Monthly**
Scholar		$ 122.00
Scholar & Spouse		$ 405.00
Scholar & Child		$ 247.00
Scholar & Children		$ 398.00
Scholar, Spouse & Child		$ 530.00
Scholar, Spouse & Children		$ 681.00

Medical / Dental **Policy #: 078152 / 078153**		**Monthly**
Scholar		$ 133.00
Scholar & Spouse		$ 426.00
Scholar & Child		$ 267.00
Scholar & Children		$ 418.00
Scholar, Spouse & Child		$ 560.00
Scholar, Spouse & Children		$ 711.00

	MONTHLY CALCULATION
Program Start Date:	**# of Months**
Program End Date:	**Multiplied by Rate**
	Total Due

Monthly Periods *(premium listed above is per Month)* **The coverage period for this policy is 08/15/11 through 08/14/12**.
It is the Covered Person's (scholar) responsibility to enroll for coverage each year in order to maintain continuity of coverage.

Above charges includes a 3% Baylor University administrative fee.

PAYMENT INFORMATION

Premium Payment Instructions: Make check or money order payable to **Blue Cross and Blue Shield of Texas** 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 scholar's responsibility for timely renewal payment whether or not a renewal notice is received.**

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 _____

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