Aetna Life Insurance Company **Aetna Student Health**

University of Missouri-Columbia (MU)
2017/2018 Visiting Scholar
Student/Scholar Health Insurance Enrollment Form

In order to enroll you must complete steps 1 through 5!

1. ***Complete all Student/Scholar information. Incomplete information will delay processing! Contact Aetna Student Health at 877-375-7905 for assistance.*** **APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Visiting Scholar Name: _____ _____ _____
Last Name First Name MI

Scholar ID #: _____

Email address: _____

Mailing Address: _____ _____
This address will be used for all Aetna Student Health insurance communications Apt.#

City: _____ State: _____ Zip Code: _____

Phone Number: ___ - ___ - _____ Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female
mm/dd/yy

2. List Dependents to be insured. Dependent coverage is only available if the Visiting International Scholar is covered.

Dependents	Last Name	First Name	DOB	Social Security Number	M/F
Spouse					
Child					
Child					
Child					
Child					

3. Premium Rates

Coverage will begin on the day after payment is submitted. It is my responsibility to make timely payments. Eligible Visiting International Scholars and their eligible dependents that enroll in the school-sponsored scholar health insurance plan after the 15th of a given month will be charged for one-half of the monthly premium. NOTE: This option is available only in the first month of coverage based on the initial effective date. Full payment is due at the time of initial enrollment. The half monthly rate is only available to Scholar/Dependents that enter the U.S. after the 15th of the month. Coverage will be effective the day the Scholars/Dependent enters the U.S. Students/Dependents must enroll within 31 days of entering the US.

B1	*B2*	*B3*	*B4*	*B5*	*B6*	*B7*	*B8*	*B9*	*B10*	*B11*	*B12*
August 2017	**September 2017**	**October 2017**	**November 2017**	**December 2017**	**January 2018**	**February 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

** Coverage will be effective from _____ to _____.
month/day/year month/day/year

***** Coverage is only for the 2017/2018 academic year which is between 08/01/2017 and 07/31/2018.***

	½ Month Rate 890430-V20-1	Monthly Rate 890430-V20
Visiting Scholars	☐ **$68.00**	☐ **$136.00**
Spouse	☐ **$66.50**	☐ **$133.00**
Child(ren)	☐ **$66.50**	☐ **$133.00**

Number of Months Requested	X	Monthly Premium	=	TOTAL PREMIUM

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.
APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.
WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →

4. Designate Payment Method.

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover Card. CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!! (VISA, MASTERCARD, AMERICAN EXPRESS or DISCOVER

Charge full amount: $☐☐☐☐.☐☐

Credit Card#: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date: ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address (if different from student):

5. Notice to Student/Scholar (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit MU to provide Aetna Student Health with enrollment status for purposes of eligibility under this plan**. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) can be made void. I understand that if it is later determined that I am not eligible **(see the Plan Design and Benefits Summary or Master Policy for eligibility guidelines),** the premium will be refunded, but the premium is not refundable for reasons other than eligibility**.**

It is the scholar's responsibility for timely renewal payments.

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be backdated to the first of the month for applications postmarked on or before the 15th, after the 15th coverage is effective the date after postmark. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. When applying due to a life event, please attach appropriate documentation providing proof and date of the event.**

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

Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Signature: _____**Date**:_____

SPECIAL MISSOURI NOTICE

An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs.
Your group contract holder has not purchased an optional rider for elective abortions pursuant to VAMS section 376.805.

PLEASE RETURN THIS FORM TO:
Aetna Student Health P.O. Box 14388, Lexington, KY 40512

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

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If you need a qualified interpreter, written information in other formats, translation or other services, call 877-480-4161.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

For language assistance in your language call 877-480-4161 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-480-4161. (Spanish)

欲取得繁體中文語言協助，請撥打877-480-4161，**無需付費。**(Chinese)

Pour une assistance linguistique en français appeler le 877-480-4161sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-480-4161nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-480-4161 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 877-480-4161. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-480-4161 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-480-4161. (Italian)

日本語で援助をご希望の方は、877-480-4161 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-480-4161 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-480-4161. (Polish)

Para obter assistência linguística em português ligue para o 877-480-4161 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-480-4161. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-480-4161. (Vietnamese)