Michigan State University

2017–2018 Health Insurance Enrollment Form
Visiting Scholars

In order to enroll, steps 1 through 4 must be completed. Please print clearly.

1. COMPLETE ALL STUDENT INFORMATION. INCOMPLETE INFORMATION WILL DELAY PROCESSING!			
STUDENT'S LAST NAME	FIRST NAME		MI
MSU STUDENT'S APID/ZPID NUMBER	EMAIL ADDRESS		
MAILING ADDRESS			APT #
CITY	STATE	ZIP	
STUDENT'S PHONE NUMBER	STUDENT'S DATE OF BIRTH (MM/DD/YYYY)		❑ FEMALE ❑ MALE

2. LIST DEPENDENTS TO BE INSURED. DEPENDENT COVERAGE IS ONLY AVAILABLE IF THE STUDENT IS COVERED.			
LAST NAME	**FIRST NAME**	**DATE OF BIRTH (MM/DD/YY)**	**GENDER**
SPOUSE/DOMESTIC PARTNER			❑ FEMALE ❑ MALE
CHILD			❑ FEMALE ❑ MALE
CHILD			❑ FEMALE ❑ MALE
CHILD			❑ FEMALE ❑ MALE

	DAILY** **Please multiply the rate and number of days to get your total premium.**
SCHOLAR	❑ $ 6.00 x _____ (# of days) = $_____
SPOUSE/DOMESTIC PARTNER	❑ $ 6.00 x _____ (# of days) = $_____
ONE CHILD	❑ $ 6.00 x _____ (# of days) = $_____
TWO OR MORE CHILDREN	❑ $ 12.00 x _____ (# of days) = $_____
TOTAL	**$**_____

**** Please fill in the dates for which you are requesting coverage.**

Dependents cannot be enrolled beyond the primary insured coverage dates.

Effective Date _____/_____/_____ Termination Date _____/_____/_____

Coverage dates may not extend beyond August 14, 2018. New rates will apply after this date.

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(continued)

3. DESIGNATE PAYMENT METHOD.

MAKE CHECK OR MONEY ORDER PAYABLE TO ASCENSION BENEFITS & INSURANCE SOLUTIONS OR REFER TO THE CHARGE CARD AUTHORIZATION TO CHARGE PREMIUM TO VISA OR MASTERCARD. CASH WILL NOT BE ACCEPTED.

CREDIT CARD #																EXPIRATION DATE _____/_____	
NAME OF CARDHOLDER (PLEASE PRINT)															CSV/CID CODE*:		
ADDRESS (IF CARDHOLDER IS NOT STUDENT)																	
SIGNATURE OF CARDHOLDER															CHARGE AMOUNT:	$	

* *The credit card security code, known as a CSV of CID code, is the three-digit number printed on the back of your card, usually to the right of the signature field.*

4. NOTICE TO STUDENT (SIGNATURE REQUIRED).

Enrollment Guidelines: Students who voluntarily enroll themselves and their dependents as well as automatically enrolled students (Graduate Assistants, Medical, Vet and International students) who enroll their dependents, will not receive notification prior to the deadline reminding them to reenroll. It will be the responsibility of the student to reenroll him or herself and dependents. Failure to reenroll prior to the deadline will result in a break in coverage. Coverage may not extend beyond August 14, 2018. If you are eligible for additional coverage, new rates may apply.

The information contained on this form is confidential and will not be released unless the student named in this form provides written authorization, except to comply with state or federal law or a court order. This information may also be released in the event of an emergency hospitalization, or in other circumstances which pose a threat to life or serious immediate physical harm.

PLEASE COMPLETE AND SIGN THIS FORM. APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

I have carefully read the Plan Design and Benefit Summary information and elect to enroll as indicated. Rates are not pro-rated other than as listed. I permit Michigan State University to provide Blue Cross Blue Shield of Michigan with my 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 dependents can be made void. I understand that if it is later determined that the student is not eligible for coverage, the premium will be refunded, but the premium is non-refundable for reasons other than eligibility.

Signature: _____ Date: _____

Please return this form to:

Attention: MSU Enrollment, Ascension, P.O. Box 25936, Overland Park, KS 66225

or fax to: (913) 214-9143