VISITING SCHOLARS

MICHIGAN STATE UNIVERSITY

2022–2023

MICHIGAN STATE UNIVERSITY
HEALTH INSURANCE ENROLLMENT FORM

Please complete the information on all pages. Print clearly and answer all questions thoroughly, as incomplete forms will not be accepted.

STUDENT INFORMATION.

LAST NAME		FIRST NAME	MI
MSU NUMBER		EMAIL ADDRESS	
MAILING ADDRESS			APT
CITY		STATE	ZIP
PHONE NUMBER	DATE OF BIRTH (MM/DD/YYYY)		SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE

DEPENDENT INFORMATION, IF APPLICABLE.

List Dependents to be insured. Dependent coverage is available only if the student is covered.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH
SPOUSE / DOMESTIC PARTNER				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE

SELECT THE COVERAGE AND CALCULATE THE TOTAL CHARGES.

Note: You must purchase a minimum of 30 days of coverage unless the period of time in the U.S. is less. If purchasing less than 30 days of coverage, scholar will need to provide proof for the full period of time in the U.S.

Multiply the rate and number of days to get your total premium.

	DAILY RATE	# OF DAYS	TOTAL	DATES OF COVERAGE (Fill in the dates for which you are requesting coverage.)
STUDENT	☐ $ 6.00	x ______	= $	
SPOUSE / DOMESTIC PARTNER	☐ $ 6.00	x ______	= $	
ONE CHILD	☐ $ 6.00	x ______	= $	
TWO OR MORE CHILDREN	☐ $ 13.00	x ______	= $	
TOTAL AMOUNT DUE			**= $**	

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

Dependents cannot be enrolled beyond the primary insured coverage dates.

Effective Date (MM/DD/YYYY) ____________________ Termination Date (MM/DD/YYYY) ____________________

Coverage dates may not extend beyond August 15, 2023. New rates will apply after this date.

REMIT PAYMENT IN U.S. FUNDS ONLY.

Make check or money order payable to "**Relation Insurance Services**" or complete credit card information.

Credit card authorization charge will appear as "**Student Health Insurance, Relation**" on the credit card statement.

CREDIT CARD #				EXPIRES (MM / YY) /	CSV CODE*
NAME OF CARDHOLDER (PLEASE PRINT)				CHARGE AMOUNT: $	
CARDHOLDER'S BILLING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)				APT / UNIT #	
CITY	STATE	ZIP		COUNTRY	

* 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.

By signing below, I authorize my credit card to be charged the amount listed above for the coverage selected under the Michigan State University Student Health Insurance Plan.

I ACCEPT THE FOLLOWING CANCELLATION / REFUND POLICY.

There are no premium refunds, except when the Plan participant enters the armed forces of any country, or it is determined that the student is not eligible for coverage and there are no claims on file. A refund request must be sent in writing to **clientservices@relationinsurance.com** with reason for cancellation. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to approval of Michigan State University Human Resources and/or Relation Insurance Services.

CARDHOLDER SIGNATURE ______________________________ **DATE**________________

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 15, 2023. 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.

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.

STUDENT SIGNATURE ______________________________ **DATE**________________

RETURN THIS FORM TO MSU HUMAN RESOURCES, 1407 S HARRISON, STE 110, EAST LANSING, MI 48823 OR FAX TO **(517) 432-3862**

If there are any discrepancies between this document and the Plan Certificate, the Plan Certificate will govern.