Cleveland State University-OPT
2009-2010 Student and Dependent Enrollment Form

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

- Please note the enrollment deadline dates are as stated below. Enrollment Forms received after the deadline date will not be accepted.
- Enrollment in this plan for Dependents must take place at the same time as enrollment for the Student.
- Before enrolling in this plan, please take note of the Pre-Existing Condition limitation.

1. Complete all Student information. Incomplete information will delay processing.

Student Name: _____
Last Name First Name MI

Student ID#: _____ Email Address: _____

U.S. Mailing Address: _____
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 student is covered.

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

3. Select Enrollment Period

You must check one: □ Graduate Student □ Undergraduate Student

812829-OPT12	A	B	C	D
	Annual Coverage 8/13/09 – 8/12/10 Deadline to Enroll: 9/21/09	**Fall Semester Coverage 8/13/09 – 1/15/10** Deadline to Enroll: 9/21/09	**Spring/Summer Semester Coverage 1/16/10 – 8/12/10** Deadline to Enroll: 2/16/10	**Summer Semester Coverage 5/23/10 – 8/12/10** Deadline to Enroll: 6/21/10
1. Student Only	□ $1,535	□ $658	□ $877	□ $345
2. Spouse	□ $5,100	□ $2,194	□ $2,906	□ $1,146
3. Each Child	□ $2,748	□ $1,182	□ $1,564	□ $617

4. *Designate Payment Method.*

Make check or money order payable to Aetna Student Health or refer to the charge card authorization to charge premium to Visa or MasterCard (Please note Visa and MasterCard are the only credit cards accepted). CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!!(VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)

Charge full amount: $□□□□.□□

Credit card# (Visa or MasterCard only): □□□□□□□□□□□□□□□□ Exp. Date: □□/□□

Signature of Cardholder:_____

Printed Name and Address(if different from student):

5. Notice to Student (Signature required)

Enrollment Guidelines: To enroll, complete the enrollment form and remit the appropriate premium prior to the stated deadline date. Applications received after the effective date and prior to the published deadline will be accepted and given an effective date retroactive to the policy start date. Application and premium received after the deadline date will not be accepted and premium will be refunded. Premiums are not pro-rated. There is no renewable option and no refunds are available.

Please Note: Only newly enrolled Spring students and their dependents have an option to elect Spring or Summer Coverage.

I have carefully read the on-line brochure and elect to enroll as indicated. I permit Cleveland State University to provide Aetna Student Health with my enrollment status for purposes of eligibility under this Plan. 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 for coverage, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

Signature: _____Date: _____

ENCLOSE PAYMENT WITH ENROLLMENT FORM AND MAIL TO:
Aetna Student Health P.O. Box 15706, Boston, MA 02215-0014