Cleveland State University
International Visiting Scholars
2009/2010 Health Insurance Enrollment Form
In order to enroll you must complete steps 1 through 5!

1. Complete all Scholar information. Incomplete information will delay processing!

Scholar Name: _____
Last Name First Name MI

Social Security#: _____ _____ Email Address: _____

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 Scholar is covered.*

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

3. Select Enrollment Period

	A	B
812829-V12	**8/13/09-8/12/10 Deadline to enroll: 9/21/09**	**Daily Please multiply the rate and number of Days to get your total premium.**
1. Scholar	☐ **$1,715**	☐ **$5.00 X _____(# of Days) = $_____**
2. Spouse	☐ **$5,023**	☐ **$13.77 X _____(# of Days) = $_____**
3. Each Child	☐ $2,723	☐ **$7.47 X _____(# of Days) = $_____**

****PLEASE FILL IN THE DATES FOR WHICH YOU ARE REQUESTING COVERAGE! PLEASE NOTE: PREMIUMS ARE CUMULATIVE (EX. STUDENT+*SPOUSE = $; STUDENT + CHILD = $, etc.)***

EFFECTIVE DATE_____/_____/_____ TERMINATION DATE_____/_____/_____

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. 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(Please note: If this information is different from scholar it must be included or the application will be rejected):

5. *Notice to Scholar (Signature required)*

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.

***Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will be dated the day after postmark.**

Signature: _____Date: _____

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