University of Missouri – Kansas City (UMKC)
2009/2010 OPT Student Enrollment Form & Dependent of International Students
Accident and Sickness Insurance Plan Enrollment Form

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

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

Student Name: _____
Family Name First Name MI

School issued ID/Social Security #: _____ Email Address: _____

Mailing Address: _____
Apt. #

City: _____ State: _____ Zip Code: _____

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

2. List accompanying Dependents to be insured. Dependent coverage is only available if the Student is covered.

Dependents must be enrolled within 30 DAYS of the later date of: a) the student's effective date of coverage, or b) the date the dependent entered the USA.

Dependents	Family Name	First Name	DOB Mm/dd/yy	Social Security Number (if issued)	M/F
Spouse					
Child					
Child					
Child					

3. *Select enrollment period*

890439	Annual 08/01/09 – 07/31/10 Deadline: 9/18/09	Fall 08/01/09 – 12/31/09 Deadline: 9/18/09	Spring/Summer 01/01/10 – 07/31/10 Deadline: 2/12/10	Summer 06/01/10 – 07/31/10 Deadline: 6/18/10
Student 890439-OPT12	☐ $1,020	☐ $425	☐ $595	☐ $171
Student & Spouse 890439-OPT12-1	☐ $5,916	☐ $2,465	☐ $3,451	☐ $990
Student & Child(ren) 890439-OPT12-2	☐ $2,855	☐ $1,190	☐ $1,665	☐ $478
Student & Spouse & Children 890439-OPT12-3	☐ $7,750	☐ $3,230	☐ $4,520	☐ $1,297

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

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)

I have carefully read the brochure and elect to enroll myself and my dependents as indicated. I permit UMKC to provide Aetna Student Health 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 child(ren) 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 not refundable for reasons other than eligibility.

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

Signature: _____ Date: _____

MAIL TO: Aetna Student Health, P.O. Box 15706, Boston, MA 02215-0014