**University of Missouri – Kansas City (UMKC)**
**2009-2010 Visiting Scholar and International Student Accident and Sickness Insurance Plan Enrollment Form**
***In order to enroll you must complete steps 1 through 5.***

***1. Complete all information below. Incomplete information will delay processing***.

Visiting Student Name: _____
Last Name First Name MI

Soc Security # / Scholar ID #: _____ Email Address: _____

Mailing Address: _____
Apt. #

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female
month/day/year

***2. List Dependents to be insured - Dependent coverage is only available if the Visiting International Student is covered.***

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

***3. Premium Rates***

Coverage will begin on the day after payment is submitted. It is my responsibility to make timely payments. **Eligible Visiting International Students and their eligible dependents whom enroll in the school-sponsored student health insurance plan after the 15th of a given month will be charged for one-half of the monthly premium. NOTE: This option is available only in the first month of coverage based on the initial effective date. Full payment is due at the time of initial enrollment. The half monthly rate is only available to Students/Dependents that enter the U.S. after the 15th of the month.** Coverage will be effective the day the Student/Dependent enters the U.S. Students/Dependents must enroll within 31 days of entering the US.

| *B1* | *B2* | *B3* | *B4* | *B5* | *B6* | *B7* | *B8* | *B9* | *B10* | *B11* | *B12* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***August '09*** | ***Sept '09*** | ***Oct '09*** | ***Nov '09*** | ***Dec '09*** | ***Jan '10*** | ***Feb '10*** | ***March'10*** | ***April '10*** | ***May '10*** | ***June '10*** | ***July '10*** |
| | | | | | | | | | | | |

** Coverage will be effective from _____ to _____.
month/day/year month/day/year

***** Coverage is only for the 2009/2010 academic year which is between 8/01/09 and 7/31/10.***

| **890439-** | **½ Month Rate** | **Monthly Rate** |
|---|---|---|
| Visiting Student/Scholar | ☐ $43<br>890439-V12-4 | ☐ $86<br>890439-V12 |
| Visiting Student/Scholar & Spouse | ☐ $247.50<br>890439-V12-5 | ☐ $495<br>890439-V12-1 |
| Visiting Student/Scholar & Child(ren) | ☐ $121<br>890439-V12-6 | ☐ $242<br>890439-V12-2 |
| Visiting Student/Scholar & Spouse & Child(ren) | ☐ $325<br>890439-V12-7 | ☐ $650<br>890439-V12-3 |

***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 Visiting Scholar/International 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 Visiting Scholar/International 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**