



# Part-Time Student / Dependent Premier Plan Enrollment/Change Request

Plans are underwritten by Aetna Life Insurance Company.

**Group Information – To be completed by Aetna Student Health.**

Group Name RUTGERS UNIVERSITY-2009/2010- PART-TIME STUDENT & DEPENDENT [Control Number] 474876 Policy Number \_\_\_\_\_

**A. Type of Activity – To be completed by Rutgers University. Refer to instructions on Page 3 before completing this form. Print clearly.**

| Activity – Check all that apply                            | Effective Date/<br>Date of Event | Date of Enrollment/Reason for Change |
|--|----------------------------------|--------------------------------------|
| <b>1. Add</b>  |                                  |                                      |
| <input type="checkbox"/> Enrollment of a New Student       | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Add Spouse/Civil Union Partner    | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Add Dependent Child               | _____ / _____ / _____            | _____                                |
| <b>2. Remove</b>   |                                  |                                      |
| <input type="checkbox"/> Student Withdrawal/Termination    | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Remove Spouse/Civil Union Partner | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Remove Dependent Child            | _____ / _____ / _____            | _____                                |
| <b>3. Change</b>   |                                  |                                      |
| <input type="checkbox"/> Name Change                       | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Change Plan                       | _____ / _____ / _____            | _____                                |
| <input type="checkbox"/> Other                             | _____ / _____ / _____            | _____                                |

**B. Student Information – To be completed by the Student.**

Name (Last, First, MI) \_\_\_\_\_ Student ID# /SSN \_\_\_\_\_

U.S. Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ [E-mail Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex  Male  Female

**C. Plan Options – To be completed by the Student. Check the box that indicates the level of coverage you want.**

*Please note: Spouse/Civil Union Partner and Dependent children must purchase the exact same coverage as the Insured student*

| 474876  | A   | B  |
|---|---|--|
| <b><u>Enroll here if upgrading student and dependent coverage</u></b><br><br>Premier Plan with Rx Card--(\$250,000 Per Condition)<br>Note: The below rates <b>INCLUDE</b> the cost of mandatory HSP | <b>Fall</b><br><b>9/1/09-1/18/10</b><br><b>Deadline: 10/30/09</b> | <b>Spring/Summer</b><br><b>1/19/10-8/31/10</b><br><b>Deadline: 3/19/10</b> |
| 1A. Student-Camden<br>474876-PT12   | ( ) \$424.50  | ( ) \$ 625.50  |
| 1B. Student-Newark<br>474876-PT12-1   | ( ) \$392.75  | ( ) \$ 593.75  |
| 1C. Student-New Brunswick<br>474876-PT12-2  | ( ) \$432.00  | ( ) \$ 633.00  |
| 2. Spouse/Civil Union Partner   | ( ) \$981.00  | ( ) \$1,488.00   |
| 3. Each Child   | ( ) \$582.00  | ( ) \$ 949.00  |

**D. Other Individuals Covered** – To be completed by Student. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and date. Attach proof if full-time post-secondary student. Attach proof of disability.

| 1. Spouse or Civil Union Partner   | 2. Child   | 3. Child   | 4. Child   |
|--|--|--|--|
| <input type="checkbox"/> Add <input type="checkbox"/> Other<br><input type="checkbox"/> Remove <input type="checkbox"/> Continue Spouse  | <input type="checkbox"/> Add <input type="checkbox"/> Other<br><input type="checkbox"/> Remove <input type="checkbox"/> Continue   | <input type="checkbox"/> Add <input type="checkbox"/> Other<br><input type="checkbox"/> Remove <input type="checkbox"/> Continue   | <input type="checkbox"/> Add <input type="checkbox"/> Other<br><input type="checkbox"/> Remove <input type="checkbox"/> Continue   |
| <b>Name</b><br>Last _____<br>First _____ MI ____<br>Birthdate (mm/dd/yyyy)<br>_____ / _____ / _____<br>Social Security Number<br>_____   | <b>Name</b><br>Last _____<br>First _____ MI ____<br>Birthdate (mm/dd/yyyy)<br>_____ / _____ / _____<br>Social Security Number<br>_____   | <b>Name</b><br>Last _____<br>First _____ MI ____<br>Birthdate (mm/dd/yyyy)<br>_____ / _____ / _____<br>Social Security Number<br>_____   | <b>Name</b><br>Last _____<br>First _____ MI ____<br>Birthdate (mm/dd/yyyy)<br>_____ / _____ / _____<br>Social Security Number<br>_____   |
| <b>Other Health Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Payer Name _____<br>Policy # _____<br>Medicare ID# _____  | <b>Other Health Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Payer Name _____<br>Policy # _____<br>Medicare ID# _____  | <b>Other Health Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Payer Name _____<br>Policy # _____<br>Medicare ID# _____  | <b>Other Health Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Payer Name _____<br>Policy # _____<br>Medicare ID# _____  |
| <b>Previous Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Effective Date<br>_____ / _____ / _____<br>Termination Date<br>_____ / _____ / _____<br>Payer Name _____<br>Policy # _____<br><i>[Submit a copy of the Certificate of Creditable Coverage.]</i> | <b>Previous Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Effective Date<br>_____ / _____ / _____<br>Termination Date<br>_____ / _____ / _____<br>Payer Name _____<br>Policy # _____<br><i>[Submit a copy of the Certificate of Creditable Coverage.]</i> | <b>Previous Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Effective Date<br>_____ / _____ / _____<br>Termination Date<br>_____ / _____ / _____<br>Payer Name _____<br>Policy # _____<br><i>[Submit a copy of the Certificate of Creditable Coverage.]</i> | <b>Previous Coverage</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i><br>Effective Date<br>_____ / _____ / _____<br>Termination Date<br>_____ / _____ / _____<br>Payer Name _____<br>Policy # _____<br><i>[Submit a copy of the Certificate of Creditable Coverage.]</i> |
| Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If yes, complete Section [E]1.</i>  | If last name is different from Student's,<br>please explain:<br>_____  | If last name is different from Student's,<br>please explain:<br>_____  | If last name is different from<br>Student's, please explain:<br>_____  |
| Home or billing address same as<br>Student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If NO, complete Section [E]2.</i>   | Living with Student?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If NO, complete Section [F].</i>  | Living with Student?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If NO, complete Section [F].</i>  | Living with Student?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>If NO, complete Section [F].</i>  |

**[E.] Additional Spouse/Civil Union Partner Information** – To be completed by Student. If not applicable, please mark as "NA."

1. Employer Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

2a. Street/Apt \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

2b. Please explain why the address is different \_\_\_\_\_

**[F.] Additional Child Information** – To be completed by Student. Provide information below about children listed in Section D, if they have a different address from the student. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

|   |   |
|---|---|
| Name(s) _____<br>Street/Apt. _____<br>City _____ State _____ ZIP Code _____<br>Reason _____ | Name(s) _____<br>Street/Apt. _____<br>City _____ State _____ ZIP Code _____<br>Reason _____ |
|---|---|

**[G.] Race/Ethnicity** – To be completed by Student, at his/her option. NOTE: your response is appreciated but NOT required!

Choose a category that most closely describes you:

- American Indian or Alaskan Native     
  Black, not of Hispanic origin     
  Hispanic  
 Asian or Pacific Islander     
  White, not of Hispanic origin

**[H.] Student Signature**

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**[I.] Rutgers University Verification**

The requested activity is believed eligible and is approved by Rutgers University.

Rutgers University Representative \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Representative's Title \_\_\_\_\_

**INSTRUCTIONS**

**Rutgers University** – You must complete the Rutgers group information and Sections A and [I].

**STUDENTS** – You must complete Sections B through [H].

- Please PRINT except when a signature is requested.
- [If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.]

**Qualifying Events**

Dependent Under 31

- |  |  |
|--|--|
| D1. Loss of dependent status and otherwise eligible        | D4. Reestablish eligibility: change in marital status      |
| D2. Reestablish eligibility: residency                     | D5. Reestablish eligibility: change in parental status     |
| D3. Reestablish eligibility: nonresident full-time student | D6. Reestablish eligibility: termination of other coverage |

**CONDITIONS OF ENROLLMENT – STUDENT ACKNOWLEDGEMENT AND AGREEMENTS**

On behalf of myself and the dependents listed in this Enrollment/Change Request for, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, and any employer to give Aetna Student Health, acting on behalf of Aetna Life Insurance Company, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Aetna Life Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Aetna Life Insurance Company will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize payments as follows:

**Make check or money order payable to Aetna Student Health and forward the check to the designated entity authorized to receive the payment or refer to the charge card authorization to charge the cost of your coverage to Visa or MasterCard and the designated entity will process the charge card debit.**

**CREDIT CARD AUTHORIZATION – PLEASE PRINT CLEARLY. (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS.)**

Credit Card # (Visa or MasterCard only): \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_

Signature of Cardholder \_\_\_\_\_

Printed Name and Address (if different from student)  
\_\_\_\_\_  
\_\_\_\_\_