



Student Enrollment Request

University Of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers Graduate Fellows Student Health Insurance Plan

Plans are underwritten by Aetna Life Insurance Company.

Group Information – To be completed by the Institution.

Group Name: University Of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers University Graduate Fellows

Control/Policy Number: 812813

A. Type of Activity – To be completed by the University Of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers University Graduate Fellows. Refer to instructions on Page 3 before completing this form. Print clearly.

Activity – Check all that apply	Effective Date/ Date of Event	Date of Enrollment/Reason for Change
1. Add		
<input type="checkbox"/> Enrollment of a Student	____ / ____ / ____	_____
<input type="checkbox"/> Add Spouse	____ / ____ / ____	_____
<input type="checkbox"/> Add Dependent Child	____ / ____ / ____	_____
2. Remove		
<input type="checkbox"/> Student Withdrawal/Termination	____ / ____ / ____	_____
<input type="checkbox"/> Remove Spouse	____ / ____ / ____	_____
<input type="checkbox"/> Remove Dependent Child	____ / ____ / ____	_____
3. Change		
<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) _____ SID # _____

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.

Basic Plan	Per Month
812813-12	
Post Doc/Fellow	\$ 280.00
Post Doc/Fellow and One Dependent	\$640.00
Post Doc/Fellow and Family (Two or More Dependents)	\$812.00

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

E. Additional Spouse 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) _____ Street/Apt. _____ City _____ State _____ ZIP Code _____ Reason _____	Name(s) _____ Street/Apt. _____ City _____ State _____ ZIP Code _____ Reason _____
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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. University Of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers University Graduate Fellows School Verification

The requested activity is believed eligible and is approved by the University Of Medicine and Dentistry of New Jersey.

School Representative _____ Date ____ / ____ / ____

Representative's Title _____

INSTRUCTIONS

University Of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers University Graduate Fellows– You must complete 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 Life Insurance Company, 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 University Health Plans and forward the check to the designated entity authorized to receive the payment.

**University Health Plans, Inc.
One Battermarch Park
Quincy, MA 02169**

**If you have further questions please contact University Health Plans at 1-800-437-6448
or email info@univhealthplans.com.**