

# Auburn University

## Graduate Student Group Insurance

Optional Group Coverage Enrollment for Students and Dependents  
UnitedHealthcare Choice Plus Network Plan Option 2,3, or 4

(Please check one)

v 07/13/2016

**Initial Request:**

Graduate Assistant

INTL or GRAD (Circle one)

Do you have an assistantship?

Yes

No

**PRIMARY INSURED**

AU BANNER ID#:

Last Name:

First Name:

Middle Initial:

Gender:

Date of Birth: \_\_/\_\_/\_\_

Mailing Address:

Apt:

City:

State:

Zip Code:

AU Email Adress:

**DEPENDENT INFORMATION:**

(Dependent coverage is only available for Students insured under this plan.)

**SPOUSE**

Last Name:

First Name:

Middle Initial:

Gender:

Date of Birth: \_\_/\_\_/\_\_

**CHILD**

Last Name:

First Name:

Middle Initial:

Gender:

Date of Birth: \_\_/\_\_/\_\_

**CHILD**

Last Name:

First Name:

Middle Initial:

Gender:

Date of Birth: \_\_/\_\_/\_\_

**CHILD**

Last Name:

First Name:

Middle Initial:

Gender:

Date of Birth: \_\_/\_\_/\_\_

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company a representative of the Company or the effective date of the coverage period, whichever is later. By signing, the student acknowledges the following: 1) He/She has carefully read the bochure and elects to enroll as indicated on this enrollment form; 2) **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Auburn University

## Optional Group Coverage Enrollment for Students and Dependents

v 07/13/2016

I hereby elect to enroll in the AU Graduate Student Group Health Insurance Program and understand the following applicable rules:

1. This program is available only to AU enrolled graduate students or international students - see eligibility criteria.
2. International students who are on OPT are also allowed to enroll in this insurance
3. Once enrolled I (and any associated dependents enrolled) may not withdraw from this plan until the end of the enrollment period selected. New dependents (spouse/child) are subject to enrolling guidelines as stated in the policy.
4. I will be responsible for full payment of all premiums as charged to by bursar bill, failure to pay said premiums will result in cancellation of my schedule and collections procedures being implemented.
5. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student actively attend classes.

### Enrollment for 2016-2017:

I hereby elect the following **COVERAGE PERIOD** for myself (and associated dependents):

**FALL: 08/16/2016-02/15/2017 (six months)\***

(Student: \$973, Spouse: \$973, Child: \$973, 2+ Children: \$1929 All Dependents \$2885)

**SPRING/SUMMER: 02/16/17-08/15/2017 (six months)\***

(Student: \$957, Spouse: \$957, Child: \$957, 2+ Children: \$1897 All Dependents \$2837)

**FALL AND SPRING/SUMMER: 08/16/16-08/15/17 (one year)\***

(Student: \$1,930, Spouse: \$1,930, Child: \$1,930, 2+ Children: \$3826 All Dependents \$5722)

**SUMMER TERM: 05/16/17-08/15/17 (three months)\***

(Student: \$487, Spouse: \$487, Child: \$487, 2+ Children: \$965 All Dependents \$1443)

**Monthly: Dates: \_\_/16/\_\_ - \_\_/15/\_\_**

(Student: \$161, Spouse: \$161, Child \$161, 2+ Children: \$319 All Dependents \$477)

**Weekly: Dates: \_\_/\_\_/\_\_ - \_\_/\_\_/\_\_**

(Student: \$38, Spouse: \$38, Child \$38, 2+ Children: \$75 All Dependents \$112)

\*\*\*Please remember you must contact the insurance coordinator via email to request any additional months or days that you have not selected on this form.\*\*\*

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_