Graduate Student Group Insurance

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

Primary Insured Information

Last name ______ **First Name** ______ **Middle Initial** ______

Gender M | F **Date of Birth** (MM/DD/YYYY) / / **AU Banner ID #** ______

Phone # ______ **AU Email** ______

Mailing Address ______ **Apt #** ______

City ______ **State** ______ **Zip Code** ______

Your AU profile ☐ International Student ☐ Graduate Student ☐ VFS

Do you have assistantship? ☐ Yes ☐ No

Dependent(s) Information

Important: Dependent coverage is only available for Students insured under this plan.

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)	Relationship		Gender	
				Spouse	Child(ren)	Male	Female
			____/____/____				
			____/____/____				
			____/____/____				
			____/____/____				
			____/____/____				
			____/____/____				

✓ Please check mark the column that applies

NOTICE TO STUDENTS

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, student acknowledges the following:

1) He/She has carefully read the bochure and this enrollment form;
2) Premium will not be refunded except for ineligibility or entrance into the armed forces.

Student Signature ______ **Date** ______

Auburn University

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Insurance acknowledgement

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. All non-assistantship graduate students taking a minimum of 6 credit hours are eligible to enroll in this insurance plan on a voluntary basis. On-line credits count toward the minimum hours, but may not exceed 50% of hours required for eligibility.
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.

Enrollment for 2019-2020

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

☐ **FALL: 08/16/2019 - 02/15/2020 (six months)***
(Student: $1,022, Spouse: $1,022, Child: $1,022, 2+ Children: $2,015 All Dependents $3,008)

☐ **SPRING/SUMMER: 02/16/20 - 08/15/2020 (six months)***
(Student: $1,006, Spouse: $1,006, Child: $1,006, 2+ Children: $1,983 All Dependents $2,960)

☐ **SUMMER TERM: 05/16/20 - 08/15/20 (three months)***
(Student: $512, Spouse: $512, Child: $512, 2+ Children: $1,009 All Dependents $1,506)

☐ **Monthly: Dates: ___ / 16 / ___ - ___ / 15 / ___**
(Student: $170, Spouse: $170, Child $170, 2+ Children: $335 All Dependents $500)

CONTACT Aime McCorcle
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IMPORTANT
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**