Aetna Life Insurance Company	Aetna Student Health			
Grand Canyon University				
Students taking 12 or more credits				
2014 - 2015 Student Health Insurance Enrollment Form				
<u>In order to enroll you must complete s</u>	<u>teps 1 through 4!</u>			

<u>1.</u> <u>Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 800-859-8489</u> <u>for assistance.</u>

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.							
Student Name:							
Last Name First Name MI							
Student ID #:							
Mailing Address: Image: Constraint of the sector of th							
City:							
Phone Number:							
mm/dd/yy							

2. <u>Select Enrollment Plan</u>

Form ID: 100113-SD17	Α	В	С
	Annual	Fall	Spring/Summer Semester
	08/17/14 - 08/16/15	08/17/14-12/31/14	01/01/15-8/16/15
	Deadline: 09/14/14	Deadline: 09/14/14	Deadline: 01/25/015
1. Students taking 12 or more	□ \$2,400	□ \$1,200	□ \$1,200
credits	,		

PLEASE COMPLETE AND SIGN THE NEXT PAGE OF THIS FORM.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.

3. Designate Payment Method.

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MC, Discover & AE (please note Visa, MC, Discover & AE are the only credit cards accepted). <u>CASH WILL NOT BE</u> <u>ACCEPTED.</u>

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY !!! (VISA, MC, DISCOVER & AE ARE THE ONLY ACCEPTED CREDIT				
CARDS) Charge full amount: \$				
Credit Card#:				
Signature of Cardholder:				
Printed Name and Address (if different from student):				

4. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit Grand Canyon University to provide Aetna Student Health with 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 I am not eligible <u>(see the Plan</u> <u>Design and Summary of Benefits)</u>, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

It is the student's responsibility for timely renewal payments.

*Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. <u>When applying due to a life event</u>, please attach appropriate documentation providing proof and date of the event.

_____Date:______

ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO: AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512 OR FAX: 859-425-5200