

**University of Mississippi**  
**2017-2018 Visiting Scholar Enrollment Form**  
*In order to enroll you must complete steps 1 through 5!*

**1. Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 888-204-0473 for assistance.**

Scholar Name: \_\_\_\_\_

Scholar ID #: \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Email Address: \_\_\_\_\_

U.S. Mailing Address: \_\_\_\_\_ Apt.# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female  
 mm/dd/yy

**2. List Dependents to be insured. Dependent coverage is only available if the Scholar is covered.**

Dependents	Last Name	First Name	DOB	Social Security Number	M/F
Spouse					
Child					
Child					
Child					

**3. Select Enrollment Period**

697412-V20 8/15/17-8/14/18	<b>Daily</b>	
	Deadline: 30 days after effective date	
	<b>Effective Date:</b>	<b>* Termination Date:</b>
<b>Scholar</b>	<b># of Days:</b>	<b>x \$5.91 =</b>
<b>Spouse</b>	<b># of Days:</b>	<b>x \$5.91 =</b>
<b>Child</b>	<b># of Days:</b>	<b>x \$5.91 =</b>
<b>Children</b>	<b># of Days:</b>	<b>x \$11.82 =</b>
<b>Total Payment</b>	<b>\$</b>	

**\* Termination Date cannot extend past 8/14/18**

PLEASE READ AND SIGN THE SECOND PAGE OF THIS FORM. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.

**4. Designate Payment Method.**

\_\_\_\_\_ Check or money order payable to Aetna Student Health.

\_\_\_\_\_ Charge Card Authorization (please complete below).

**CASH WILL NOT BE ACCEPTED.**

**CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY (PLEASE NOTE THE ONLY ACCEPTED CREDIT CARDS)**

Total payment amount at this time (from page one of the enrollment form):	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>											
Credit card# (Visa, MasterCard, Discover or American Express only):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Exp.
Date:	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>														
Signature of Cardholder:	_____																		
Printed Name and Address (if different from Scholar):	_____																		

**5. Notice to Scholar (Signature required)**

I have carefully read the Plan Design and Summary of Benefits and elect to enroll as indicated. I permit University of Mississippi to provide Aetna Student Health with my 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 lawful spouse and child(ren) can be made void. I understand that if it is later determined that the Scholar is not eligible (see the Plan Design and Summary of Benefits for eligibility guidelines) for coverage, 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. When applying due to a life event, please attach appropriate documentation providing proof and date of the event.**

*Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-437-6512.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:  
Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and

Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

For language assistance in your language call 877-437-6512 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-437-6512. (Spanish)

欲取得繁體中文語言協助，請撥打877-437-6512，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-437-6512 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-437-6512 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-437-6512 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 877-437-6512. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele ni mwo 877-437-6512 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-437-6512. (Italian)

日本語で援助をご希望の方は、877-437-6512まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-437-6512 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 877-437-6512 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-437-6512. (Polish)

Para obter assistência linguística em português ligue para o 877-437-6512 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-437-6512. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-437-6512. (Vietnamese)