

STUDENT EDUCATIONAL BENEFIT TRUST  
 ENROLLMENT FOR VOLUNTARY STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

**MORGAN STATE UNIVERSITY**

**2017 - 2018**

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**PRIMARY INSURED - Complete information below for Student**

SOCIAL SECURITY #:		STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH YEAR	
<b>PERMANENT U.S. ADDRESS - House/Building Number and Street Name:</b>			
CITY:		STATE	ZIPCODE
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE	ZIPCODE
TELEPHONE #:		EMAIL ADDRESS:	

**DEPENDENT INFORMATION: Complete information below for dependents to be insured. Dependent coverage is only available for Student insured under the Plan (Please include a blank sheet for additional Dependents).**

SPOUSE or DOMESTIC PARTNER SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
CHILD (1) SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
CHILD (2) SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
CHILD (3) SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
CHILD (4) SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			

**NOTICE TO STUDENT:** Coverage will be effective the date the correct premium is received by the Company or a representative of the Company of the effective date of the coverage period, whichever is later, unless otherwise stated in the Summary Plan Document (SPD). By signing, the student acknowledges the following: (1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment application" (2) Rates are not pro-rated other than as listed on this enrollment application; (3) He/She meets the eligibility requirements for this coverage as described in the brochure: and (4) if it is later determined that the student is not eligible, the premiums will be refunded. Premium will not be refunded for ineligibility or entrance into the Armed Forces.

**NOTICE:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and/or civil penalties.

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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**MORGAN STATE UNIVERSITY**

2017 - 2018

CAMPUS / SCHOOL ATTENDING: \_\_\_\_\_

I elect to purchase coverage under the Morgan State University's Student Health Insurance Plan. Below are the choices that I have made:

**PLEASE CHECK ALL APPROPRIATE BOXES**

- INSURED CATEGORY:**
- |   |  |
|---|--|
| <input type="checkbox"/> Mandated Student           | <input type="checkbox"/> Domestic        |
| <input type="checkbox"/> Un-Mandated Student        | <input type="checkbox"/> International   |
| <input type="checkbox"/> Visiting Faculty / Scholar | <input type="checkbox"/> Student Athlete |

**MEDICAL**

- YES  OPT-OUT

<b>PERIOD CODES</b>	FALL (F)	SPR/SUM	SUMMER	3 mo continuation	MONTHLY	LESS STUD
<b>DOMESTIC PLAN</b>	8/11/2017 - 12/31/2017	1/01/2017 - 8/10/2018	5/16/2017 - 8/10/2018	GRADUATING STUDENTS	QE ONLY	
Student	<input type="checkbox"/> \$363	<input type="checkbox"/> \$365	<input type="checkbox"/> \$153	<input type="checkbox"/> \$289.38	\$60.67	
Student + Spouse	<input type="checkbox"/> \$1,330	<input type="checkbox"/> \$1,335	<input type="checkbox"/> \$560	<input type="checkbox"/> \$1,059.34	\$222.08	\$161.42
Student + Children	<input type="checkbox"/> \$941	<input type="checkbox"/> \$945	<input type="checkbox"/> \$396	<input type="checkbox"/> \$749.69	\$157.17	\$96.50
Family	<input type="checkbox"/> \$1,907	<input type="checkbox"/> \$1,915	<input type="checkbox"/> \$803	<input type="checkbox"/> \$1,519.25	\$318.50	\$257.83

**VISION**

- YES  OPT-OUT

**PERIOD CODES**

ANNUAL

Student Only	<input type="checkbox"/> \$72.00
Student & Child(ren)	<input type="checkbox"/> \$156.00
Student & Spouse	<input type="checkbox"/> \$231.00
Student & Family	<input type="checkbox"/> \$341.00
<b>NOT AVAILABLE</b>	

**DENTAL**

- YES  OPT-OUT

**PERIOD CODES**

ANNUAL

Student Only	<input type="checkbox"/> \$240.48
Student + 1	<input type="checkbox"/> \$487.32
Student + 2	<input type="checkbox"/> \$1,263.36
<b>NOT AVAILABLE</b>	

**SHORT TERM COVERAGE CALCULATION (This section only applies to Traveling Faculty/Scholars)**

Effective Date of Coverage _____ / _____ / _____	Termination Date of Coverage _____ / _____ / _____
MONTH      DAY      YEAR	MONTH      DAY      YEAR
Number of Days with Coverage _____	Cost Per Day of Coverage _____

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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CAMPUS / SCHOOL ATTENDING: \_\_\_\_\_

QUALIFYING EVENT(s):

- Student and dependent(s) are eligible for coverage without a qualifying event
- Student is starting classes in the middle of the Fall, Spring or Summer Term
- Student or dependent was covered under COBRA continuation coverage and such coverage was exhausted
- Student or dependent lost, or will lose, eligibility for other coverage due to death, divorce, legal separation, termination of employment or termination of the employer contributions for the coverage, termination of employment in a class eligible for coverage, or reduction in hours of employment resulting in a loss of coverage.
- The Student no longer, or will no longer, live or work in a health plan's service area ( and there is no other coverage available under the plan), or the plan no longer offers coverage to a class of similar individuals , which are inclusive of students and/or dependents.
- Student or dependent qualifies, or will qualify, under the standard events that are defined and set forth by HIPAA.
- Student is actively engaged in completing classes from the prior semester due to incompletes that were approved by the University

IT IS UNDERSTOOD THAT ANY ENROLLMENT THAT QUALIFIES FOR COVERAGE UNDER A QUALIFYING EVENT MUST BE SUPPORTED BY DOCUMENTATION OF THE TERMINATION OF THE OTHER COVERAGE WITH THE EFFECTIVE DATE OF SAID TERMINATION STATED AND APPROVED BY THE UNIVERSITY, OR AN AUTHORIZED REPRESENTATIVE OF THE UNIVERSITY. NOTICE OF THE ABOVE EVENTS MUST BE PROVIDED TO THE UNIVERSITY WITHIN 31 DAYS OF THE OCCURENCE OF THE EVENT. IF TIMELY NOTICE IS NOT PROVIDED, THE STUDENT WILL BE REQUIRED TO WAIT UNTIL THE FOLLOWING TERM TO ENROLL.

AUTHORIZED REPRESENTATIVE'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PAYMENT INFORMATION

CREDIT CARD AUTHORIZATION - Please be sure to print clearly (VISA and MasterCard are the only credit cards accepted by the Trust.)

- VISA
- MASTERCARD

Charges by Line of Coverage - Subtotals:

Medical \$ \_\_\_\_\_ Short Term<sup>(1)</sup> \$ \_\_\_\_\_  
Vision \$ \_\_\_\_\_ Full Charge Amount \$ \_\_\_\_\_  
Dental \$ \_\_\_\_\_<sup>(1)</sup> Restricted to Traveling Faculty / Scholars

Prorated Monthly Rates (Plan I):<sup>(2)</sup>

Months until next AP \_\_\_\_\_  
Monthly Rates \$60.67  
Total Charge for Remainder of AP \_\_\_\_\_

<sup>(2)</sup> Restricted to Qualifying events only / 15 of the Month Rule applies

LAST NAME ON CARD:		FIRST NAME ON CARD:		MIDDLE INITIAL:
CREDIT CARD NUMBER: _____ / _____ / _____		CVS #: # _____	EXPIRATION DATE: _____ / _____	
CARD HOLDER SIGNATURE: _____				
BILLING ADDRESS - House/Building Number and Street Name: _____				
CITY:		STATE	ZIPCODE	
TELEPHONE #:		EMAIL ADDRESS:		

APPLICATIONS MUST BE APPROVED AND SUBMITTED BY MORGAN STATE UNIVERSITY

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_