IOWA STATE UNIVERSITY
2009-2010 ON-CALL INTERNATIONAL STUDENT ENROLLMENT FORM
(Medical Evacuation / Repatriation Benefits)
In order to enroll step 1 through 5 must be completed!

1. Complete all Student information. Incomplete information will delay processing.

Student Name: _____
Last Name First Name Middle Initial

Student ID: _____ Email Address: _____
(UID or social security number)

Billing Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number: (_____) _____Date of Birth:_____/_____/_____ Sex ☐ M ☐ F Campus or location: _____

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

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

3. Select Enrollment Period.

812805 - ONC12	A	B	C
	Annual Coverage 08/10/2009 – 08/08/2010 Deadline to Enroll: **8/7/2010**	**Fall Semi-Annual Coverage 08/10/2009 - 2/10/2010** Deadline to Enroll: 8/**7/2010**	**Spring/Summer Semi-Annual Coverage 2/11/2010 - 08/08/2010** Deadline to Enroll: **8/7/2010**
1. Student Only	☐ $ 66	☐ $ 36	☐ $ 36
2. Spouse	☐ $ 66	☐ $ 36	☐ $ 36
3. Each Child	☐ $ 66	☐ $ 36	☐ $ 36

4. Designate Payment Method

Make check or money order payable to Aetna Student Health, or refer to the charge card authorization to charge premium to Visa or Mastercard (please not Visa and MasterCard are the only credit cards accepted).

Credit Card Authorization – Please be sure to print clearly.

Charge Full amount: $_____

Credit Card (MasterCard or Visa Only) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Signature of Cardholder _____

Printed name and address of cardholder if different from above.

5. Notice to Student(signature required)

I have carefully read the brochure and elect as indicated. Rates are not pro-rated. I permit Iowa State University to provide Aetna Student Health with my student 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 the student is not eligible, the premium will be refunded, but the premium is not refundable for reasons other than eligibility. I understand that I and any declared dependents must have an in-force medical insurance policy that provides worldwide coverage. Failure to maintain an in-force medical insurance policy will void any obligation for service from On-Call International. I understand that On-Call International services are available anytime a non-U.S. covered participant is at his/her campus location or traveling, and do not apply when a non-U.S. participant is in his/her country of origin. I understand that U.S. students studying in the U.S. are eligible for all services when more than 100 miles from their permanent residence and for selected services on campus.

Student: _____ Date: _____

*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 no be accepted in the absence of a Qualifying Event.

MAIL TO: Aetna Student Health. P.O. Box 15706, Boston, MA 02215-0014