Royal Thai Embassy
2011-2012 Dependent Accident and Sickness Insurance Plan Enrollment Form
In order to enroll you must complete steps 1 through 5.

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

Visiting Scholar Name: _____
Last Name First Name MI

Soc Security # / Scholar ID #: _____ Email Address: _____

Mailing Address: _____
Apt. #

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female
month/day/year

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

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

3. Premium Rates

Coverage will begin on the Plan Effective Day. It is my responsibility to make timely payments.

B1	*B2*	*B3*	*B4*	*B5*	*B6*	*B7*	*B8*	*B9*	*B10*	*B11*	*B12*
Sept '11	**Oct '11**	**Nov '11**	**Dec '11**	**Jan '12**	**Feb '12**	**March'12**	**April '12**	**May '12**	**June '12**	**July '12**	**Aug '12**

** Coverage will be effective from _____ to _____.
month/day/year month/day/year

***** Coverage is only for the 2011/2012 academic year which is between 9/01/2011 and 8/31/2012.***

	½ Month Rate		Monthly Rate	
Spouse	474927-D14-2	☐ $163.59	474927-D14-1	☐ $ 327.17
Each Child	474927-D14-2	☐ $101.04	474927-D14-1	☐ $202.08

Number of Months Requested	X	Monthly Premium	=	TOTAL PREMIUM

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 note Visa and MasterCard are the only credit cards accepted). CASH WILL NOT BE ACCEPTED.

CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!!(VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)

Charge full amount: $☐☐☐☐.☐☐

Credit card# (Visa or MasterCard only): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Signature of Cardholder:_____

Printed Name and Address(if different from student):

5. Notice to Dependent (Signature Required)

I have carefully read the brochure and elect to enroll my dependents as indicated. I permit Royal Thai Embassy 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 spouse and child(ren) can be made void. I understand that if it is later determined that the Student is not eligible for coverage, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature: _____ Date: _____

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