BROKER:_____
DATE: _____

COLLEGE STUDENT HEALTH PLANS
Plan Enrollment Form

Student Resources (SPC) **Aetna Company| Coventry**

Please Print Clearly- Failure to Provide All Information May Delay or Void Your Coverage

Student Last Name:		MI:
Student First Name:	Social Security/TIN #:	
Home Country:	Visa Type: F1 ☐ J1 ☐	M1 ☐
Date of Birth (Month/Day/Year):	Male ☐ Female ☐	
Mailing Address:		
City: State:	Zip Code:	
Phone #: Email:		

Student Information

Student ID: University or College :

Expected Graduation Date:

*Basic

Student/Scholar	Monthly-PMPM	Annual
-Student 18 & older	☐ $75	☐ $750
Dependents		
Spouse	☐ $75	
Each Child	☐ $75	

*Pay in **FULL** and receive 2-months free

*__FULL__ payment must be paid for enrollment

Please include an administration processing fee per enrollee (non-refundable) ☐ $25 (Processing Fee)

*Plus

Student/Scholar	Monthly-PMPM	Annual
-Student 18 & older	☐ $125	☐ $1,250
Dependents		
Spouse	☐ $125	
Each Child	☐ $125	

*Pay in **FULL** and receive 2-months free

*__FULL__ payment must be paid for enrollment

Please include an administration processing fee per enrollee (non-refundable) ☐ $25 (Processing Fee)

PREMIUM DUE NOW: $ _____

Method of Payment: ☐ Money Order ☐ Check ☐ Credit Card
(Make Payable to: Five Points Health Benefit Plans)

Please bill my care for my insurance premium shown above and include the appropriate processing fee ☐
Credit Card Authorization: ☐ MasterCard ☐ Discover ☐ American Express ☐ Visa

Cardholder Number:

Cardholder Name:

Expiration Date:

Security Code:

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Schedule of Benefits. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not prorated other than as listed on this enrollment card; 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 premium will be refunded. PREMIUM WILL NOT BE REFUNDED EXCEPT FOR INELIGIBILITY OR ENTRANCE INTO THE ARMED FORCES.

I UNDERSTAND THAT I MUST BE A COLLEGE STUDENT/SCHOLAR AT COLLEGE TO PURCHASE THIS HEALTH COVERAGE:
Student Signature:_____
Date: _____
Please type your full legal name on the signature line to serve as your official signature for this application

Dependents-Complete information below for dependents to be insured

Note: Dependent Coverage is available only for students/scholars insured under this plan.

Spouse Last Name:_____ **First Name**: _____
Date of Birth (Month/Day/Year): _____ Visa Type: F1 ☐ J1 ☐ M1 ☐
Gender: M ☐ F ☐

Dependent 1 Last Name:_____ **First Name:** _____
Date of Birth (Month/Day/Year): _____ Visa Type: F1 ☐ J1 ☐ M1 ☐
Gender: M ☐ F ☐

Dependent 2 Last Name:_____ **First Name:** _____
Date of Birth (Month/Day/Year): _____ Visa Type: F1 ☐ J1 ☐ M1 ☐
Gender: M ☐ F ☐

Dependent 3 Last Name:_____ **First Name:** _____
Date of Birth (Month/Day/Year): _____ Visa Type: F1 ☐ J1 ☐ M1 ☐
Gender: M ☐ F ☐

FOR QUESTIONS PLEASE CONTACT:
Coverage for Students, Five Points Health Benefit Plans, LLC.
6006 North Mesa Street – Suite 108
El Paso, TX 79912

Phone: 915-803-4198
Fax: 915-519-0261

Applications can be sent via email to alejandra@fivepointsmecplan.com or by fax to the address above