

Iowa State University  
Visiting Scholar Health Insurance Form

**Change in Enrollment for Visiting Scholar**

**Visiting Scholar Info:**

University ID number \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

**Drop:** *Provide copy of airline ticket(s)*

Drop Family Member     Departure from USA    Date of Event \_\_\_\_\_

Name of Family Member(s) dropping \_\_\_\_\_

**Add:** *Provide copy of Passport*

Add Family member     Arrival in the USA    Date of Event \_\_\_\_\_

**List All Covered Dependents:** *(Dependent coverage is only available if the scholar is covered)*

	Last Name	First Name	Date of Birth	Gender (M/F)
Spouse/Domestic Partner				
Child				
Child				

**New Monthly Payment and Enrollment coverage is for (check one):**

- Self Only    **\$158.00 per month** = \$131.00 insurance premium + \$27.00 health facility fee
- Self & Spouse/Domestic Partner    **\$330.00 per month** = \$276.00 insurance premium + \$54.00 health facility fee
- Self & Child(ren)    **\$276.00 per month** = \$249.00 insurance premium + \$27.00 health facility fee
- Self, Spouse/Domestic Partner & Child(ren)    **\$448.00 per month** = \$389.71 insurance premium + 54.00 health facility fee

*Billing is based on calendar months. Monthly payments are not pro-rated for less than a month's coverage.  
Example: arrival date of January 20 and departure date of February 15 – total you will be billed is for 2 monthly payments*

**Agreement/Certification:**

The premium rates shown above are for the insurance period from August 1, 2017 through July 31, 2018. I understand that deductibles and co-pays are calculated on an annual basis starting August 1<sup>st</sup> of each year.

I certify that, after this Enrollment Form was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given either expressly or by implication, has been knowingly withheld. I understand that Aetna Life Insurance Company will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or conceal any material fact, Aetna Life Insurance Company will be entitled to declare the health care contracts applied for void, and to refuse allowance of benefits to any person there under.

I authorize any health care provider to release medical records to Aetna Life Insurance Company when reasonably related to the health care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

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

