

Aetna Student Health  
Enrollment Form for Mid Term Changes  
**Northern Arizona University**  
Complete and return form to the NAU Insurance Office

ID# \_\_\_\_\_

Student Name: \_\_\_\_\_

*Last (Family) Name*

*First (Given) Name*

Gender: ( ) Male ( ) Female

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL \_\_\_\_\_

**Please Note: Students have 31 days from date of qualifying life event to apply. After that, they may apply during next open enrollment period. Documentation of change is required, i.e. marriage certificate, certificate of coverage termination, etc. If unable to obtain official documentation within 31 day grace period contact the Fronske Health Center at (928) 523-6343.**

Effective Term Desired: ( ) Fall ( ) Spring/Summer ( ) Summer Effective Date: \_\_\_\_\_

I hereby request to enroll in the Student Health Insurance Plan due to the following qualifying life change

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Notice to Student (Signature required)***

I have carefully read the brochure and elect to enroll as indicated. I permit Northern Arizona University 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.

I understand that by choosing this enrollment option I authorize Northern Arizona University to charge my student account for the insurance premium for this semester and each semester thereafter while I remain a student at the University. I also understand that if I choose to reverse my insurance selection I must file a form at the Northern Arizona University Insurance office located at the Fronske Health Center with a request to change prior to the end of the next open enrollment period.

Enrollment Guidelines: If the request is received after the semester start date, but prior to the published deadline, then coverage is backdated to the start of the semester. A pro-rate of premium is only available for Qualifying Events, such as involuntary loss of other insurance coverage.

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: \_\_\_\_\_

**Office Use:**

Effective Date of Coverage: \_\_\_\_\_

Pro-rated Premium: \_\_\_\_\_

Plan Code: \_\_\_\_\_

Location Code: \_\_\_\_\_