THE OFFICE OF STUDENT ACCOUNTS
STUDENT HEALTH INSURANCE PLAN (SHIP)
ADMINISTRATIVE POLICY, PROCEDURES, AND GUIDELINES
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT HEALTH INSURANCE POLICY</td>
<td>1</td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE CHARGE GUIDELINES</td>
<td>1</td>
</tr>
<tr>
<td>Fall Term</td>
<td></td>
</tr>
<tr>
<td>Spring Term</td>
<td></td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE SITE OPENING / CLOSING GUIDELINES</td>
<td>1</td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE WAIVER DEADLINES JUSTIFICATION</td>
<td>1</td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE WAIVER GUIDELINES</td>
<td>2</td>
</tr>
<tr>
<td>Domestic</td>
<td></td>
</tr>
<tr>
<td>International</td>
<td></td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE WAIVER APPROVAL GUIDELINES</td>
<td>2</td>
</tr>
<tr>
<td>NEW JERSEY FAMILY CARE (NJFC) WAIVER GUIDELINES</td>
<td>2</td>
</tr>
<tr>
<td>Fall Term</td>
<td></td>
</tr>
<tr>
<td>Spring Term</td>
<td></td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE WAIVER APPEAL REVIEW BOARD</td>
<td>2</td>
</tr>
<tr>
<td>STUDENT HEALTH INSURANCE LATE WAIVER APPEALS GUIDELINES</td>
<td>3</td>
</tr>
<tr>
<td>Uncontested Late Waiver Appeals</td>
<td></td>
</tr>
<tr>
<td>Contested Late Waiver Appeals</td>
<td></td>
</tr>
<tr>
<td>EARLY TERMINATION REQUEST</td>
<td>4</td>
</tr>
<tr>
<td>GUIDELINES FOR ENROLLMENT REQUEST AFTER APPROVED WAIVERS</td>
<td>4</td>
</tr>
<tr>
<td>Qualifying Life Event (QLE)</td>
<td></td>
</tr>
<tr>
<td>What is it?</td>
<td></td>
</tr>
<tr>
<td>Process to Check eligibility</td>
<td></td>
</tr>
<tr>
<td>SAMPLE FORMS &amp; DOCUMENTS</td>
<td>6-36</td>
</tr>
<tr>
<td>Waiver Requirement Checklist</td>
<td></td>
</tr>
<tr>
<td>Waiver Requirements (ACA)</td>
<td></td>
</tr>
<tr>
<td>UHP Health Insurance Step-by-Step Guide</td>
<td></td>
</tr>
<tr>
<td>How to Know If Your Waiver is Applied</td>
<td></td>
</tr>
<tr>
<td>Sample Annual Waiver Questionnaire (Domestic)</td>
<td></td>
</tr>
<tr>
<td>Sample Annual Waiver Approved Email (Domestic)</td>
<td></td>
</tr>
<tr>
<td>Sample Annual Waiver Questionnaire (International)</td>
<td></td>
</tr>
<tr>
<td>Sample Annual Waiver Approved Email (International)</td>
<td></td>
</tr>
<tr>
<td>Sample QLE Enrollment Form Grad (Domestic)</td>
<td></td>
</tr>
<tr>
<td>Sample QLE Enrollment Form Undergrad (Domestic)</td>
<td></td>
</tr>
<tr>
<td>Sample QLE Enrollment Form Grad (International)</td>
<td></td>
</tr>
<tr>
<td>Sample QLE Enrollment Form Undergrad (International)</td>
<td></td>
</tr>
</tbody>
</table>
Montclair State University values the health of its students and remains dedicated to offering all students access to quality healthcare and affordable health insurance plans to aid in protecting against financial hardships that may stem from high healthcare expenses. While most of our undergraduate and graduate students are in good health and face few severe illnesses while in school, medical and psychological issues can emerge at any time, occasionally without warning. Many health concerns may not become apparent initially until early adulthood.

The high cost of healthcare in the United States exemplifies a potentially severe financial risk to students. The scarcity of adequate insurance coverage can result in transient or enduring interruptions in students' academic achievements. Therefore, Montclair State University requires all students registered as full-time** (as defined below) to maintain health insurance.

- Undergraduate students enrolled in twelve (12) or more credits. **
- Graduate students enrolled in nine (9) or more credits. **

Most students are automatically charged a health insurance premium as part of the course registration process. To ensure waiver compliance, students will have the opportunity to waive/opt-out of the Student Health Insurance Plan (SHIP) by providing evidence of a comprehensive Affordable Care Act (ACA) compliant health insurance plan online to our third-party broker University Health Plans (UHP).

The 2021-22 Aetna Student Health Plan Design and Benefits Summary will help you understand the benefits and levels of coverage offered by the Aetna Student Health-sponsored student health insurance plans.
STUDENT HEALTH INSURANCE CHARGE GUIDELINES

In keeping with our institutional responsibility to protect the health and well-being of our students, Montclair State University requires all domestic undergraduate students enrolled in 12 or more credit hours, domestic graduate students registered in 9 or more credit hours, and F1 and J1 International students meeting any of the above-referencing criteriums to maintain health insurance coverage throughout the academic year. The University's stance regarding health insurance aids in protecting our students against unexpected high medical costs and ensures quality care while at school or traveling abroad. Montclair State University automatically charges Student Health Insurance to any registered student who meets the criteria listed below:

FALL TERM
- Undergraduate students carrying twelve (12) or more credit hours in the Fall semester.
- Graduate students carrying nine (9) or more credit hours in the Fall semester.
- F1 and J1 International Students meeting one of the class/credit hour combinations referenced above

SPRING TERM
- Any "New" (was not here for the Fall term or was part-time in the Fall term) Undergraduate student carrying twelve (12) or more credits in the Spring semester.
- Any "New" (was not here for the Fall term or was part-time in the Fall term) Graduate student carrying nine (9) or more credits in the Spring semester.
- Any "New" (was not here for the Fall term or was part-time in the Fall term) F1 and J1 International Students meeting one of the class/credit hour combinations

Graduate and Undergraduate students enrolled in an online program are not automatically charged for the Student Health Insurance. Students meeting this criterion who would like to enroll in the School Sponsored Health Insurance administered by Aetna Student Health may make a formal enrollment request. Similarly, doctoral students completing their dissertations may follow the same process to petition for enrollment into the School-sponsored Health Insurance Program (SHIP). Please note that this request will assess the health insurance premium with the understanding that the student will remain enrolled in the coverage until the policy termination date.

STUDENT HEALTH INSURANCE SITE OPENING / CLOSING GUIDELINES

The Student Health Insurance waiver/enrolment site will open on or around mid to late July for the Fall term and close on or around mid to late October. The waiver site will open on or around mid-December and close on or around mid to late March for the Spring term. All students will receive a general email blast notification informing them that the website site is open, outlining the criterion for waiving/enrollment the school-sponsored health insurance and highlighting the established deadline. We will send targeted email communication to students after the specified deadline and the inception of the Late Waiver Appeal Period. Students who fail to act during the open waiver/enrollment period or the Uncontested Late Waiver Appeal Period will be enrolled into the Health Insurance Plan and become financially responsible for the associated cost of the Health Insurance Premium.

STUDENT HEALTH INSURANCE WAIVER DEADLINES JUSTIFICATION

Montclair State University establishes waiver and appeal deadline(s) to comply with its contractual and financial obligations to the school-sponsored health insurance provider (Aetna Student Health). The Health Insurance Fees are itemized charges on a students' account/invoice which are emailed to students on the 1st and 15th of each month during the course of a semester or term. We notify students of the waiver process through internal and external email communications, acceptance materials, orientations, divisions/advisors, emails, the university website, etc. Ultimately, it is the students' responsibility to verify the account's accuracy and the timely application of waivers. That said, we strongly advocate for our students to periodically monitor their accounts via Nest and Self-Service Banner (SSB) and their MSU email account, as it is the primary source of itemized account/billing information and student communication.
STUDENT HEALTH INSURANCE WAIVER GUIDELINES (DOMESTIC STUDENTS)

All domestic students may opt to waive coverage under the Student Health Insurance Program (SHIP) if they have health insurance that meets the plan requirements listed in the Waiver Requirement Student Checklist. Students will need to provide information about their current coverage via the University Health Plans website to initiate the waiver process. Accepted waivers apply only to the academic year in which it is filed. Waivers typically process within five (5) to seven (7) business days after submission. Students not charged the student health insurance fee do not require the completion of a waiver. Students are responsible for viewing their accounts to verify the occurrence of the assessment before attempting to waive.

STUDENT HEALTH INSURANCE WAIVER GUIDELINES (INTERNATIONAL STUDENTS)

Montclair State University will enroll all F-1 and J-1 international students into the school-sponsored health insurance plan. They may only opt-out (waive) if proof of coverage by an ACA-compliant insurance provider, filed, and approved in the U.S. is provided. Typically, we will not support plans marketed solely to International students as they do not fall in the category as accepted comparable alternative coverage (please verify before purchase). They are often not filed and approved in the U.S. and have limited benefits, provider networks, and coverage periods that do not comply with the requirements of acceptable coverage per the Montclair State insurance mandate. GBG Insurance, HDL Global Specialty, ISO, PGH (United), PSI, Student Medicover, and Tata AIG are examples of companies that do not meet the waiver requirements. J-1 visa holders must meet the U.S. Department of State's health insurance minimums. Please see Mandatory Health Requirements on The Office of Global Engagement site and information on waiving the university insurance. International students that have a health insurance plan that meets all of the waiver requirements can request the International Student Waiver Form by contacting University Health Plans at 800-437-6448 or info@univhealthplans.com.

STUDENT HEALTH INSURANCE WAIVER APPROVAL GUIDELINES

Students who meet all of the waiver criteria will be eligible to opt out of the school-sponsored health insurance plan (SHIP). Once the waiver is accepted, verified, and approved by University Health Plans (UHP), a credit (in the form of a waiver) totaling the amount of the health insurance charge will be posted to the student's account within five (5) to seven (7) business days. If the waiver application results in a credit or overpayment, the system will automatically process a refund within seven (7) to fourteen (14) days (provided this does not occur within the refund blackout periods).

NEW JERSEY FAMILY CARE (NJFC) WAIVER GUIDELINES

Students who receive their coverage through New Jersey Family Care (NJFC) will be allowed additional time to provide documentation as we are aware that the New Jersey Family Care (NJFC) application process takes a minimum of 60 to 90 days after applying. Therefore, students falling into this classification must adhere to the following deadlines and criteria:

FALL TERM
- Proof that NJFC coverage begins September 1st or sooner
- Complete SHIP Waiver Appeal by November 30th

SPRING TERM
- Proof that NJFC coverage begins February 1st or sooner
- Complete SHIP Waiver Appeal Form by April 30th

** Students that accumulate claims during the time of SHIP enrollment cannot the SHIP coverage removed **

STUDENT HEALTH INSURANCE WAIVER APPEAL REVIEW BOARD (SHI-WARB)

Comprised of the Lead Administrator, who facilitates the daily operations of the Student Health Insurance waiver/enrollment process, the Director and Associate Director of the Office of Student Accounts, and the AVP of Finance, make up the Student Health Insurance Waiver Appeal Review Board and are charged with reviewing all uncontested/contested Late waiver appeal requests. ** Note: Appeal requests (uncontested or contested) that exceed twenty-five (25) days from the official waiver deadline date will not be accepted. All decisions are final **
STUDENT HEALTH INSURANCE LATE WAIVER APPEAL GUIDELINES

Students who do not waive the school-sponsored health insurance plan before the deadline have the option to submit a Late Waiver Appeal Form via University Health Plans (UHP). The late waiver appeal guideline consists of two levels; uncontested and contested. All waivers are subject to review by the “Health Insurance Waiver Appeal Review Board”. The guidelines of both are outlined below.

UNCONTESTED LATE WAIVER APPEAL GUIDELINES

The Office of Student Accounts will establish an "Uncontested Late Waiver Appeal" which shall be known as the “Waiver Deadline Appeal”. The length of the uncontested late waiver appeal (Waiver Deadline Appeal) period will be based on any outside determinants that may contribute to the likelihood of students failing to act to waive the school-sponsored health insurance but shall not exceed twenty-five (25) days from the official waiver deadline date. A final determination regarding the length of this period will occur after careful consideration of these determinants and approval by the Director of the Office of Student Account with actions ensuring compliance carried out by representative(s) from University Health Plans, the Student Health Insurance Administrator, and other individuals as deemed necessary. Examples of some such detriments taken into consideration are but are not limited to:

- COVID-19 Pandemic & Re-acclimation to In-Person Classes/Activities
- Incoming Freshmen Population
- Number of Non-Responders (student who did not act)

Any student wishing to submit a Waiver Deadline Appeal during the Uncontested period must:

- Complete a Late Waiver Appeal Form
- Submit proof of health insurance in the form of an insurance ID card or a letter from their insurance carrier
- Clearly state the reason for requesting a late waiver

Once submitted, University Health Plans (UHP) and the Student Health Insurance Administrator will:

- Confirm that insurance meet the waiver criteria
- Confirm the submitted documentation is acceptable

If the student meets the requirements and standards mentioned above, the SHI Waiver Appeal Review Board will approve the "Waiver Deadline Appeal".

CONTESTED LATE WAIVER APPEAL GUIDELINES

The Student Accounts Office defines a "Contested Late Waiver Appeal" period as any time after the "Uncontested Late Waiver Appeal" or Waiver Deadline Appeal period. If a student contacts University Health Plans or any Montclair State University Office during the contested period, we will inform them that the Official Waiver Deadline and Waiver Deadline Appeal have passed, and we can no longer accept or review any requests. However, if a student believes they have extenuating circumstances that caused them to miss the deadlines and warrants additional review or if a student feels the assessment was unjust, they must submit a formal appeal via University Health Plans.

Extenuating circumstances can vary for students, but some examples warranting allowance of a Contested Late Waiver Appeal are but limited to:

- Pre-existing condition, severe/debilitating illness, or accident
- Involuntary call to active military duty
- Late or Back Dated Registration
- Disruption or Interference in current medical coverage or medical treatment
- Other extraordinary/emergency circumstances, such as natural disasters.

If the reason offered by the student is deemed sufficient to justify approval of their "Contested Late Waiver Appeal," (as determined by University Health Plans (UHP) and representative(s) within the Office of Students, an approval will be granted
based on **extenuating circumstances** as a **one-time courtesy**. In that case, the waiver will take effect for the term in which the student submitted the “Contested Late Waiver Appeal”.

It is essential to note the following about the Student Health Insurance Contested Late Waiver Appeals process:

Missed deadlines will not be sufficient for an appeal as Montclair State University, and University Health Plans communicate deadline information via email with students.

Missed/disregarded email communications from any Montclair State University Office will not be sufficient for an appeal as per University Policy; students must familiarize themselves with the contents of all official University notifications and react accordingly to guidance dictated in the correspondence and reply to those requiring a response.

Health cost-sharing plans are not considered comparable coverage as all insurance plans must be fully compliant with the Affordable Care Act (ACA) provisions and provide access to local primary care providers in the Montclair State University area. Contested Late Waiver Appeals will not be approved solely based on having comparable alternative health insurance coverage.

**Students have thirty (30) days after the waiver deadline to file a Late Waiver Appeal. We will notify students of the final decision no later than two (2) weeks after their submission date.**

---

**EARLY TERMINATION (NOT PERMITTED)**

Montclair State University / Aetna Student Health **does not** prorate health insurance premiums or adjust effective dates of coverage. We will not remove students from SHIP coverage based upon graduation, withdrawal from the University, or new insurance plans post waiver deadline. If you are enrolled (opt-in or forced), the coverage will remain in effect until the policy's termination date (typically on or around mid-August unless otherwise specified).

**GUIDELINE FOR ENROLLMENT AFTER WAIVING THE STUDENT HEALTH INSURANCE PLAN**

If a student waives the school-sponsored health insurance plan but later experiences a change in coverage or qualifying life event (QLE), the student may petition Aetna Student Health directly to enroll. For no lapse in coverage to occur, an application and documentation (proof) must be submitted (directly to Aetna Student Health) within 30 days from the onset of the QLE date.

Examples of Qualifying Life Event (QLE) include but are not limited to:

- Change in marital status.
- Loss of employment.
- Loss of insurance coverage
- Turning age 26

Please note, the student's application is subject to review and approval by Aetna Student Health, provided the student meets the specified criteria outlined on the Qualifying Life Event Enrollment Form. If a student is granted enrollment under the basis of a Qualifying Life Event, Aetna Student Health will use the daily QLE rate to calculate the cost of the students' policy, and the student will be responsible for remitting payment directly Aetna Student Health.
Montclair State University mandates that all domestic and international full-time undergraduate students (12 credits or more), and full-time graduate students (9 credits or more) must enroll in the school sponsored Student Health Insurance (SHIP) or be covered by a comprehensive Affordable Care Act (ACA) compliant health insurance plan. To ensure compliance, full-time students are automatically billed for the SHIP.

If you have health insurance through another provider, it must meet the stated minimum requirements to qualify for a waiver. (Upon request, you must be able to provide verifiable proof) Foreign insurance, non-(state) HMO’s, and travel insurance plans are not acceptable as alternative coverage as they do not meet the minimum requirements.

If you do not have coverage through another provider that meets these minimum requirements, then you must enroll in the School sponsored Student Injury and Sickness Insurance Plan, or you will be automatically enrolled, after the waiver deadline.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>School Sponsored Student Injury and Sickness Plan</th>
<th>Requirements for Alternative Coverage</th>
<th>My Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Maximum (Per Insured Person, Per Policy Year)</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Policy Deductible (Per Insured Person, Per Policy Year)</td>
<td>$250 in-network</td>
<td>Student needs to be financially responsible for the deductible</td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient Services (Includes surgery, laboratory, X-Ray, ER, test and procedures)</td>
<td>20% coinsurance in-network</td>
<td>Student needs to be financially responsible for the cost share</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Preferred Provider)</td>
<td>$5,000</td>
<td>No higher than $8,550</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs (In-Network)</td>
<td>$15/$45/$75/$100</td>
<td>Prescription drug coverage must be included</td>
<td></td>
</tr>
<tr>
<td>Mental Illness &amp; Substance Use Disorder Treatment</td>
<td>Covered as any other sickness</td>
<td>Covered as any other sickness</td>
<td></td>
</tr>
<tr>
<td>Pre-existing Conditions</td>
<td>Covered with no limitations</td>
<td>Covered with no limitations</td>
<td></td>
</tr>
<tr>
<td>Claims processing office must be based in the U.S.</td>
<td>Insurance Policy is filed and approved in the U.S.</td>
<td>Insurance Policy must be filed and approved in the U.S.</td>
<td></td>
</tr>
<tr>
<td>Coverage in New Jersey, Nationwide and while traveling outside the U.S. (Emergency only coverage is not acceptable)</td>
<td>National PPO Provides access to comprehensive healthcare in the campus area</td>
<td>Provides access to comprehensive healthcare in the campus area</td>
<td></td>
</tr>
<tr>
<td>Coverage Period</td>
<td>8/15/21 – 8/14/22 (Fall) 01/02/2022 – 8/14/22 (Spring)</td>
<td>Entire enrollment period of the academic year</td>
<td></td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>20% co-insurance</td>
<td>Student needs to be financially responsible for the cost share</td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation / Repatriation</td>
<td>Unlimited</td>
<td>$50,000 medical evacuation/$25,000 repatriation</td>
<td></td>
</tr>
</tbody>
</table>

**This checklist is provided for reference purposes only. Students must waive/enroll through the online waiver/enrollment during the applicable open waiver/enrollment period.**

If you need assistance please contact University Health Plans at 800-437-6448.
Montclair State University mandates that all **full-time undergraduate students (12 credits or more)**, and **graduate students enrolled in (9 credits or more)** must enroll in the school sponsored Student Health Insurance (SHIP) or be covered by a comprehensive **Affordable Care Act (ACA) compliant health insurance plan**.

**AFFORDABLE CARE ACT (ACA) – WHAT YOU NEED TO KNOW**

What is the Affordable Care Act (ACA)?

(A) The Patient Protection and Affordable Care Act, commonly known as the ACA, was signed into law in 2013 and provides certain requirements for health insurance, such as covering preventive care obtained at an in-network provider at no cost.

What does the ACA mean for my health insurance coverage?

(A) Under the ACA, everyone must be covered by a health insurance plan that meets certain minimum essential coverage requirements.

What is “minimum essential coverage”?

(A) An insurance plan that’s certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as “minimum essential coverage.”

**Examples of qualifying health coverage:**

*(This information retrieved from [https://www.healthcare.gov/fees/plans-that-count-as-coverage/](https://www.healthcare.gov/fees/plans-that-count-as-coverage/))*

- Any health plan bought through the Health Insurance Marketplace®
- Individual health plans bought outside the Health Insurance Marketplace®, if they meet the standards for qualified health plans
- Any “grandfathered” individual insurance plan you’ve had since March 23, 2010, or earlier
- Any job-based plan, including retiree plans and COBRA coverage
- Medicare Part A or Part C (but Part B coverage by itself doesn’t qualify)
- Most Medicaid coverage, except for limited coverage plans
- The Children’s Health Insurance Program (CHIP)
- Coverage under a parent’s plan
- Most student health plans (check with your school to see if the plan counts as qualifying health coverage)
- Health coverage for Peace Corps volunteers
- Certain types of veterans’ health coverage through the Department of Veterans Affairs
- Most TRICARE plans
- Department of Defense Nonappropriated Fund Health Benefits Program
- Refugee Medical Assistance
- State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with your high-risk pool plan to see if it counts as qualifying health coverage)

*See a more detailed list of types of plans that do and don’t count as qualifying health coverage from the IRS.*
Step-by-Step University Health Plans (UHP) Health Insurance Waiver Guide
(w/Submission & Approval Emails)

www.universityhealthplans.com/montclair
Step-by-Step University Health Plans (UHP) Health Insurance Waiver Guide
(w/Submission & Approval Emails)
Correct Phone #
Waiver successfully submitted
Confirmation email of Health Insurance Waiver Received

7/28/2021 @ 1:04 PM

Montclair State University Insurance Waiver

University Health Plans <info@univhealthplans.com>

To: [Redacted]

Dear [Redacted],

We have received your request for a waiver. Another email will be sent within 2-3 business days that states if your waiver form has been approved or denied. If it is denied, you will have a chance to prove your insurance plan is active.

The enrollment waiver process is annual. Please review your student status and health needs each year to make an informed decision.

Your confirmation number is [Redacted].

Please use this information if you contact University Health Plans at 800-437-6448.

If you lose your insurance coverage, you may qualify for special enrollment rights. You must contact University Health Plans and submit a qualifying event enrollment form and payment within 31 days of the date you lost your other coverage.

University Health Plans
833-201-1705

---

Insurance Waiver Application Approved email received

7/28/2021 @ 11:29 PM

Insurance Waiver Application Approved

University Health Plans <info@univhealthplans.com>

To: [Redacted]

Dear [Redacted],

Your insurance waiver has been approved. Please allow up to 5 business days for the insurance charge to be removed from your student account.

As a reminder, you are responsible for medical expenses once this waiver is approved and you are responsible for finding providers covered by your insurance plan when you are in need of medical care.

Please retain a copy of this confirmation page and reference the confirmation number when contacting University Health Plans if you have any questions concerning this transaction.

Your confirmation number is [Redacted].
Your transaction date is [Redacted].
HOW TO KNOW YOUR WAIVER IS APPLIED

The approval of your health insurance waiver does not remove the original charge from your student account; it authorizes the application of a “Health Insurance Waiver” payment (credit) to offset the cost of the health insurance fee (refer to samples below). Both the charge and the waiver (payment/credit) will remain listed on your semester invoice (account activity).

Student Schedule and Bill
(updated on the 1st & 15th)

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Waiver</td>
<td>7/29/21</td>
<td>-2,274.00</td>
</tr>
<tr>
<td>Mandatory Fees</td>
<td></td>
<td>$487.50</td>
</tr>
<tr>
<td>Course Fees</td>
<td></td>
<td>$208.00</td>
</tr>
<tr>
<td>Other Fees</td>
<td></td>
<td>$2,369.00</td>
</tr>
<tr>
<td>• UG Health Insurance Fee</td>
<td>9/22/21</td>
<td>$2,274.00</td>
</tr>
<tr>
<td>• Commencement Fee · 202220 BS</td>
<td>9/19/21</td>
<td>$95.00</td>
</tr>
<tr>
<td>• UG Health Insurance Fee</td>
<td>7/27/21</td>
<td>$2,274.00</td>
</tr>
<tr>
<td>Tuition</td>
<td></td>
<td>$6,161.70</td>
</tr>
<tr>
<td>Term Balance:</td>
<td></td>
<td>$6,952.26</td>
</tr>
<tr>
<td>Term Balance removing the Authorized Aid amount:</td>
<td></td>
<td>$768.20</td>
</tr>
</tbody>
</table>

Student Account Activity
(Reflects Account Activity in Realtime)
Montclair State University  
Student Health Insurance Plan  
Annual Waiver Form (Domestic Students ONLY)  
20XX – 20XX Academic Year

Pre-Waiver Form Questionnaire

It is important that students and families make an informed decision regarding their health insurance coverage. Before waiving the Montclair State University Student Health Insurance Plan, carefully review your current coverage and determine that it meets each of the following requirements.

1. I understand that I am required to complete a Waiver Form at the beginning of each academic year.
   - [ ] Yes  - [ ] No

2. I am currently enrolled in a health insurance plan and I agree to maintain health insurance coverage throughout the remainder of the academic year.
   - [ ] Yes  - [ ] No

3. I acknowledge by waiving the Student Health Insurance Plan, I will be solely responsible for any medical expenses I may incur and neither the University nor the Student Health Insurance Plan will be held responsible.
   - [ ] Yes  - [ ] No

QUESTIONNAIRE INELIGIBILITY MESSAGE

Based on the responses provided, your plan does not meet the waiver requirements; therefore, you cannot complete this form. If you believe this is not correct, please go back to the previous page to carefully read the questions and review your answers. If you need assistance, please contact University Health Plans at 800-437-6448.

*If you get this message you cannot proceed – Contact University Health Plans for assistance (800) 437-6448*

ANNUAL WAIVER FORM

STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>[ ] First Name</td>
</tr>
<tr>
<td>Last Name</td>
<td>[ ] Last Name</td>
</tr>
<tr>
<td>Student ID</td>
<td>[ ] Must include &quot;M&quot; in CWID</td>
</tr>
<tr>
<td>Student Type</td>
<td>[ ]</td>
</tr>
<tr>
<td>Email address</td>
<td>[ ] msu email address</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>[ ] MM/DD/YYYY (Required Format)</td>
</tr>
</tbody>
</table>

INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company Name</td>
<td>[ ] ?</td>
</tr>
<tr>
<td>Member ID Number</td>
<td>[ ]</td>
</tr>
<tr>
<td>Type of Insurance</td>
<td>[ ]</td>
</tr>
<tr>
<td>Insurance Company Phone</td>
<td>[ ] ?</td>
</tr>
</tbody>
</table>
Optional: to assist in a timely review of your insurance policy we recommend uploading a copy of the front and back of your ID card and a summary of benefits. If you have been asked to provide supporting documentation in the past this will help expedite your waiver review process.

File may not exceed 10 MB each

File 1:

File 2:

I certify that my insurance coverage is in effect and I expect it to remain in effect during the 2021-2022 academic year. The submission of this waiver form including all information herewith constitutes truthful and accurate statements.

Montclair State University and its contractors reserve the right to verify the insurance you are submitting. You may be required to provide coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the Student Health Insurance Plan. By submitting this waiver request, you agree that your current insurance plan may be contacted for confirmation that you have the required coverage for the policy year.

Please note, once you click “apply” below you will receive an immediate response that your waiver was successfully submitted. Should you not receive an immediate response with your confirmation number, please contact University Health Plans at 800-437-6448 as this would mean you did not successfully submit the waiver form.

My submission of this form will be used as an electronic signature. This signature certifies that I am covered by the insurance plan as described above.

Please check your information before clicking on Submit.
STOP

IF YOU DID NOT RECEIVE A CONFIRMATION EMAIL
YOU DID NOT COMPLETE THE HEALTH INSURANCE WAIVER!!

Sample Waiver Confirmation Page and Confirmation Email

Montclair State University
STUDENT HEALTH INSURANCE PLAN
Annual Waiver Form
2021-2022 Academic Year

Dear [FIRST NAME],

We have received your request for a waiver. Another email will be sent within 2-3 business days that states if your waiver form has been approved or denied. If it is denied, you will have a chance to prove your insurance plan is active.

The enrollment/waiver process is annual. Please review your student status and health needs each year to make an informed decision.

Your confirmation number is [WAIVER ID]

Please use this information if you contact University Health Plans at 800-437-6448

If you lose your insurance coverage, you may qualify for special enrollment rights. You must contact University Health Plans and submit a qualifying event enrollment form and payment within 31 days of the date you lost your other coverage.
Montclair State University Student Health Insurance Plan 20XX-20XX
INTERNATIONAL STUDENT ANNUAL WAIVER REQUEST

Please Note: Montclair is requiring all international students to be insured with an ACA compliant, filed and approved policy in the U.S. Please note, health insurance plans marketed solely to international students are often not filed and approved in the U.S., have limited benefits, provider networks and/or coverage periods that do not comply with the Montclair State University insurance requirements. GBG Insurance, HDL Global Specialty, ISO, PGH (United), PSI, Student Medicover, and Tata AIG are examples of companies do not meet the waiver requirements.

QUESTIONNAIRE
Please answer the following questions by checking off “Yes” or “No”.
All questions are required. Do not skip any of the below questions.

1. I have confirmed my plan is filed and approved in the United States and compliant with the Affordable Care Act.
   □ Yes □ No
2. I understand that I am required to complete a Waiver Form at the beginning of each academic year.
   □ Yes □ No
3. I am currently enrolled in a health insurance plan and I agree to maintain health insurance coverage throughout the remainder of the academic year.
   □ Yes □ No
4. I acknowledge by waiving the Student Health Insurance Plan, I will be solely responsible for any medical expenses I may incur and neither the University nor the Student Health Insurance Plan will be held responsible.
   □ Yes □ No

All fields below marked with * are required

* First Name:
* Last Name
* Student ID:
* Date of Birth:
* Email Address:
* Insurance Company Name:
* Member ID:
* Insurance Country:
* Subscriber (Policy Holder) Name:
* Subscriber (Policy Holder) Relation:

Please include:
□ Copy of the front and back of your insurance card
□ Copy of your plan summary

I certify that my insurance coverage is in effect and I expect it to remain in effect during the 2021-2022 academic year. The submission of this waiver form including all information herewith constitutes truthful and accurate statements:

Montclair State University and its contractors reserve the right to verify the insurance you are submitting. You may be required to provide coverage documents and/or other records demonstrating that you meet the school’s requirements for waiving the Student Health Insurance Plan. By submitting this waiver request, you agree that your current insurance plan may be contacted for confirmation that you have the required coverage for the policy year.

The student will automatically be enrolled into the Montclair Student Health Insurance Plan unless documented proof of current enrollment in a comparable health insurance plan.

----------------------------------------
Student Signature
----------------------------------------
Date
Aetna Life Insurance Company  Aetna Student Health
Montclair State University
"SAMPLE" Domestic Graduate Student Health Insurance Plan
Qualifying Life Event Enrollment Form
In order to enroll you must complete steps 1 through 5!

1. Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 1-877-480-4161 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Student Name: ___________________________ ___________________________ ___________________________
Last Name First Name MI

Email address: ____________________________________________________________

Mailing Address: __________________________________________________________
This address will be used for Aetna Student Health insurance communications

City: ___________________________ State: ___________________________ Zip Code: ___________

Phone Number: ___________-_________-_________ Date of Birth: ___________ / ___________ / ___________ Sex: ☐ Male ☐ Female

Student ID: ___________________________

2. Select Enrollment Plan

☐ Full Time Graduate Student Base Plan
686164-LQE22-3

Enrollment Period: 08/15/XX-08/14/XX

DEADLINE: Within 31 days of Loss of Coverage

Coverage Begin Date: ___________ / ___________ / ___________

Coverage End Date: 08/14/XX

☐ $12.21/day X ___________ (# of days)

Student Total: $

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.
APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.
WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.
3. **Designate Payment Method.**

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

<table>
<thead>
<tr>
<th>CREDIT CARD AUTHORIZATION—PLEASE PRINT CLEARLY!!!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge full amount: $</td>
</tr>
<tr>
<td>Credit Card#:</td>
</tr>
<tr>
<td>Exp. Date:</td>
</tr>
<tr>
<td>Signature of Cardholder:</td>
</tr>
<tr>
<td>Printed Name and Address (if different from student):</td>
</tr>
</tbody>
</table>

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

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. I permit Montclair State University to provide Aetna Student Health with 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 can be made void. I understand that if it is later determined that I am not eligible (see the Plan Design and Benefits Summary or the Master Policy for eligibility guidelines), the premium will be refunded, minus any claims paid, but the premium is not refundable for reasons other than eligibility.

It is the student’s responsibility for timely renewal payments.

5. Do we have your permission to communicate electronically with you regarding this enrollment form and this Student Health Insurance Plan?  Yes ______  No ______

*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. Enrollment Forms received after the deadline will not be accepted. Unless there is a significant life change that directly affects applicant’s insurance coverage. When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.

Enclose payment with enrollment form & mail to:

AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512

OR

FAX: 859-425-5200
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93738), 1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)
Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)
欲取得繁體中文語言協助, 請撥打您ID卡上所列的號碼, 無需付費。 (Chinese)
Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)
Para sa tulong sa wala na nasa Tagalog, tawagan ang nakalistaang numero sa iyong ID card nang walang bayad. (Tagalog)
Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)
In order to enroll you must complete steps 1 through 5!

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。 (Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای برانگیزه ی به زبان فارسی به بدون هزینه، این شماره ی که بر روی کارت شناسایی شما آمده است تماس بگیرید. (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ của quý vị. (Vietnamese)
Montclair State University
"Sample" Domestic Undergraduate Student Health Insurance Plan
Qualifying Life Event Enrollment Form
In order to enroll you must complete steps 1 through 5!

1. Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 1-877-480-4161 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Student Name: ____________________________________________

Last Name: ___________________________ First Name: ___________________________ MI: ___________________________

Email address: ____________________________________________

Mailing Address: ____________________________________________
This address will be used for Aetna Student Health insurance communications

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Phone Number: ___________________________ Date of Birth: __/__/____ Sex: ☐ Male ☐ Female

Student ID: ____________________________________________

2. Select Enrollment Plan

☐ Full Time Undergraduate Students Base Plan 686164-LQE22

Enrollment Period: 08/15/XX-08/14/XX

DEADLINE: Within 31 days of Loss of Coverage

Coverage Begin Date: __/__/____

Coverage End Date: 08/14/XX

☐ $4.91/day X _________ (# of days)

Student Total: $

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.
3. Designate Payment Method.

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

<table>
<thead>
<tr>
<th>CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge full amount: $__________________________</td>
</tr>
<tr>
<td>Credit Card#: _________________________________</td>
</tr>
<tr>
<td>Exp. Date: <strong>/</strong>/____</td>
</tr>
<tr>
<td>Signature of Cardholder: _______________________</td>
</tr>
<tr>
<td>Printed Name and Address (if different from student): ________________________________</td>
</tr>
</tbody>
</table>

4. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. I permit Montclair State University to provide Aetna Student Health with 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 can be made void. I understand that if it is later determined that I am not eligible (see the Plan Design and Benefits Summary or the Master Policy for eligibility guidelines), the premium will be refunded minus any claims paid. It is the student’s responsibility for timely renewal payments.

5. Do we have your permission to communicate electronically with you regarding this enrollment form and this Student Health Insurance Plan?  Yes ______ No ______

*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. Enrollment Forms received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant’s insurance coverage. When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.

Fully insured student health insurance plans are underwritten by Aetna Health and Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Health and Life Insurance Company. Aetna Student Health™ is the brand name for products and services provided by Aetna Health and Life Insurance Company and its applicable affiliated companies (Aetna).

Signature: ___________________________ Date: ___________________________

ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:
AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512
OR
FAX: 859-425-5200

AL SH HEnroll 01
NJ
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您ID卡上所列的號碼，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French Creole)
In order to enroll you must complete steps 1 through 5!
1. Complete all Student information. Incomplete information will delay processing! Contact Aetna Student Health at 1-877-480-4161 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

Student Name: ________________________________ ________________________________
Last Name    First Name    MI

Email address: ____________________________________________

Mailing Address: ____________________________________________
This address will be used for Aetna Student Health insurance communications
Apt. #

City: ____________________________________________
State: ____________________________________________
Zip Code: ____________________________________________

Phone Number: __________________-____-________
Date of Birth: ______/____/____
Sex: □ Male □ Female

Student ID: ____________________________________________

2. Select Enrollment Plan

□ Option LQE22: Full Time International Graduate Base Plan Students

Enrollment Period: 08/15/XX-08/14/XX

DEADLINE: Within 31 days of Loss of Coverage

Coverage Begin Date: ______/____/____

Coverage End Date: 08/14/XX

□ $12.21/day X _________ (# of days)

Student Total: $

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.

APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.

WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.

AL SH HEnroll 01

NJ
3. **Designate Payment Method.**

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

<table>
<thead>
<tr>
<th>CREDIT CARD AUTHORIZATION—PLEASE PRINT CLEARLY!!!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge full amount: $___________________________</td>
</tr>
<tr>
<td>Credit Card#: ___________________________________</td>
</tr>
<tr>
<td>Exp. Date: _____________________</td>
</tr>
<tr>
<td>Signature of Cardholder: ____________________________________________</td>
</tr>
<tr>
<td>Printed Name and Address (if different from student): __________________________</td>
</tr>
</tbody>
</table>

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

I have carefully read the policy plan provisions including all enrollment guidelines, and elect to enroll as indicated above. I permit Montclair State University to provide Aetna Student Health with 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 can be made void. I understand that if it is later determined that I am not eligible, the premium will be refunded, minus any claims paid, but the premium is not refundable for reasons other than eligibility.

It is the student’s responsibility for timely renewal payments.

5. Do we have your permission to communicate electronically with you regarding this enrollment form and this Student Health Insurance Plan?  Yes _____ No _____

*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. Enrollment Forms received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant’s insurance coverage. When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.*

Fully insured student health insurance plans are underwritten by Aetna Health and Life Insurance Company. Self-insured plans are funded by the applicable school, with administration services provided by Aetna Health and Life Insurance Company. Aetna Student Health is the brand name for products and services provided by Aetna Health and Life Insurance Company and its applicable affiliated companies (Aetna).

Signature: ______________________________________ Date: __________________

**ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:**
AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512
OR
FAX: 859-425-5200
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 4030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您ID卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wikang Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعرفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)
In order to enroll you must complete steps 1 through 5!
1. **Complete all Student information. Incomplete information will delay processing!** Contact Aetna Student Health at 1-877-480-4161 for assistance. Enrollment must be completed for each semester if the Annual Plan option is not selected.

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student ID</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Select Enrollment Plan**

<table>
<thead>
<tr>
<th>8862-QE22-1 Full Time International Undergraduate Base Plan Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location code: International Undergraduate</td>
</tr>
<tr>
<td>Enrollment Period: 08/15/XX-08/14/XX</td>
</tr>
<tr>
<td>DEADLINE: Within 31 days of Loss of Coverage</td>
</tr>
<tr>
<td>Coverage Begin Date:</td>
</tr>
<tr>
<td>Coverage End Date: 08/14/XX</td>
</tr>
</tbody>
</table>

$4.91/day X ________ (# of days)

**Student Total: $**

**PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.**

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

**WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION.**
Aetna Life Insurance Company            Aetna Student Health

Montclair State University
"SAMPLE" International Undergraduate Student Health Insurance Plan
Qualifying Life Event Enrollment Form
In order to enroll you must complete steps 1 through 5!

3. **Designate Payment Method.**

Make check or money order payable to Aetna Student Health. Refer to the charge card authorization to charge premium to Visa, MasterCard, American Express or Discover. CASH WILL NOT BE ACCEPTED.

<table>
<thead>
<tr>
<th>CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge full amount: $________</td>
</tr>
<tr>
<td>Credit Card#: ________________________________</td>
</tr>
<tr>
<td>Exp. Date: <strong>/</strong>/____</td>
</tr>
<tr>
<td>Signature of Cardholder: ________________________</td>
</tr>
<tr>
<td>Printed Name and Address (if different from student):</td>
</tr>
</tbody>
</table>

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

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit Montclair State University to provide Aetna Student Health with enrollment status for purposes of eligibility under this plan. I warrant that the information I have provided on this application form is true and correct. I am aware that if I provide false information, my coverage can be made void. I understand that if it is later determined that I am not eligible (see the Plan Design and Benefits Summary or the Master Policy for eligibility guidelines), the premium will be refunded, minus any claims paid, but the premium is not refundable for reasons other than eligibility.**

It is the student’s responsibility for timely renewal payments.

5. **Do we have your permission to communicate electronically with you regarding this enrollment form and this Student Health Insurance Plan?**

Yes [ ] No [ ]

*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. Enrollment Forms received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant’s insurance coverage. **When enrolling due to a life event, please attach appropriate documentation providing proof and date of the event.**

Fully insured student health insurance plans are underwritten by Aetna Health and Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Health and Life Insurance Company. Aetna Student HealthSM is the brand name for products and services provided by Aetna Health and Life Insurance Company and its applicable affiliated companies (Aetna).

Signature: ___________________________________________  Date: ____________________

**ENCLOSE PAYMENT WITH ENROLLMENT FORM & MAIL TO:**
AETNA STUDENT HEALTH BENEFIT P.O. BOX 14388 LEXINGTON, KY 40512
**OR**
FAX: 859-425-5200
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHB Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711
For language assistance in your language call the number listed on your ID card at no cost. (English)
Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)
欲取得繁體中文語言協助，請拨打您 ID 卡上所列的號碼，無需付費。 (Chinese)
Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)
Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)
Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

(阿拉伯) للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية.

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)
In order to enroll you must complete steps 1 through 5!