Johns Hopkins University
2018-2019 Student Health Insurance Pro-rated Enrollment Form

In order to enroll you must complete steps 1 through 6 ***Name of School:_____ Grad/UGrad:_____***

1. ***Complete all Student information. Incomplete information will delay processing!***

Student Name: _____ _____ _____
Last Name First Name M.I.

Student ID Number: _____ Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Sex: ___ Male ___ Female
mm/dd/yyyy

2. ***List Dependents to be insured. Dependent coverage is only available if the student is covered.***

Dependents	Last Name	First Name	DOB	Social Security #	M/F
Spouse/ *Domestic Partner					
Child					
Child					
Child					

Same sex Domestic Partner only.

3. ***Review Enrollment Rates***

Monthly effective date span

	8/15/18-8/14/19	9/15/18-8/14/19	10/15/18-8/14/19	11/15/18-8/14/19	12/15/18-8/14/19	1/15/19-8/14/19	2/15/19-8/14/19	3/15/19-8/14/19	4/15/19-8/14/19	5/15/19-8/14/19	6/15/19-8/14/19	7/15/19-8/14/19
Student	$2,076	$1,903	$1,730	$1,577	$1,384	$1,211	$1,038	$865	$692	$519	$346	$173
Spouse/ Domestic Partner*	$3,665	$3,344	$3,043	$2,731	$2,430	$2,119	$1,808	$1,526	$1,215	$914	$603	$303
One Child	$1,697	$1,548	$1,409	$1,265	$1,125	$981	$837	$707	$563	$423	$279	$139
Two or More Children	$2,279	$2,079	$1,892	$1,698	$1,511	$1,318	$1,124	$949	$756	$568	$375	$188

4. ***Fill in the rates and applicable effective date from the above chart***

Please note: Your effective date is considered the day after your loss of coverage. Enrollment is pro-rated on the 15th of each month. Example: If your effective date is 2/12, you would fall under the 1/15/19-8/14/19 for a pro-rate of $1,211.

	Rate	Effective Date	Termination Date
Student	$		8/14/2019
Spouse	$		8/14/2019
One Child	$		8/14/2019
Two or More Children	$		8/14/2019
Newborn Pro-Rate(based on Date of Birth)	$		8/14/2019

Total Premium Enclosed: $_____

PLEASE SIGN THE SECOND PAGE OF THIS FORM. WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →

5. *Designate Payment Method*

Make check or money order payable to Consolidated Health Plans and submit to the address listed below or to make a payment by credit card please include a daytime telephone number for us to contact you_____.

6. *Notice to Student (Signature required)*

Enrollment Guidelines: This pro-rated application can be used ONLY for students/dependents that are enrolling in the policy due to a significant life change that has taken place within 31 days of enrolling in this plan. Please attach supporting documentation. All termination dates are 8/14/2019.

I have carefully read the brochure and elect to enroll as indicated. Rates are not prorated other than as listed. I permit the university to provide Consolidated Health Plans with my enrollment status for the purpose 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 my dependent(s) coverage can be made void. I understand that if it is later determined that I am not eligible, the premium will be refunded, unless a claim has been filed, but the premium is not refundable for reasons other than eligibility.

Signature: _____ Date: _____

Completed applications should be sent directly to:

Johns Hopkins University
Office of the Registrar
75 Garland Hall
3400 N. Charles Street
Baltimore, MD 21218-2688
ASENInsurance@jhu.edu
Fax: 410-516-6477

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.

*Examples of Qualifying Life Events:

Person to be Enrolled	Reason for Late Enrollment	A copy of the following documentation is required	CHP must receive the completed enrollment form and appropriate documentation within:	The effective date of the new coverage will be:
Student	Termination of Prior Coverage	Insurance document showing the date of termination	31 days of following prior coverage termination	The date of prior coverage termination
Spouse	Termination of Prior Coverage	Insurance document showing the date of termination	31 days following prior coverage termination	The date of prior coverage termination
Spouse	Entry into U.S.	Identification page of passport and page with U.S. entry date stamp	31 days following date of entry into U.S.	The date of entry into the U.S.
Spouse	Marriage to Student	Marriage Certificate	31 days following date of marriage	The date of marriage
Child(ren)	Termination of prior coverage	Insurance document showing the date of termination	31 days following prior coverage termination	The date of prior coverage termination
Child(ren)	Birth	Birth Certificate, if available	31 days following date of birth	The date of birth
Child(ren)	Adoption	Official adoption papers showing date of adoption	31 days following adoption	The date of adoption