2021–2022

DEPENDENT ENROLLMENT FORM

MARICOPA COMMUNITY COLLEGES

INTERNATONAL STUDENT HEALTH INSURANCE PLAN (ISHIP)

Complete the information below. Please print clearly and answer **all** questions, then mail to the address listed below prior to the applicable enrollment deadline date. Incomplete forms will not be accepted. **For questions about enrollment, please contact Relation Insurance Services at (800) 537-1777.**

1. ENTER STUDENT INFORMATION:

STUDENT'S LAST NAME	STUDENT'S FIRST NAME		MI
STUDENT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)			APT/UNIT #
CITY		STATE	ZIP
STUDENT'S DATE OF BIRTH (MM/DD/YYYY)	☐ FEMALE ☐ MALE	STUDENT'S PHONE NUMBER	STUDENT'S SCHOOL ID NUMBER
STUDENT'S EMAIL ADDRESS			OK TO CONTACT YOU VIA EMAIL? ☐ YES ☐ NO
ARE YOU AN INTERNATIONAL STUDENT? ☐ YES ☐ NO	IF YES, WHAT IS YOUR HOME COUNTRY OR COUNTRY OF REGULAR DOMICILE?		PASSPORT VISA TYPE: ☐ F1 ☐ J1 ☐ OTHER _____

2. SELECT THE COLLEGE YOU ATTEND:

☐ Chandler-Gilbert CC ☐ Estrella Mountain CC ☐ Gateway CC ☐ Glendale CC ☐ Mesa CC
☐ Paradise Valley CC ☐ Phoenix College ☐ Rio Salado College ☐ Scottsdale CC ☐ South Mountain CC

3. SELECT THE COVERAGE YOU WISH TO PURCHASE AND CALCULATE THE TOTAL CHARGES:
(DEPENDENT COVERAGE PERIOD MUST BE THE SAME AS THE STUDENT'S COVERAGE PERIOD)

	FALL 08/11/2021 to 01/14/2022	**SPRING / SUMMER** 01/15/2022 to 08/10/2022
ENROLLMENT DEADLINE DATE	**09/11/2021**	**02/15/2022**
SPOUSE / DOMESTIC PARTNER	☐ $ 683.00	☐ $ 904.00
EACH CHILD*	☐ $ 683.00	☐ $ 904.00
TOTAL AMOUNT DUE	**= $**	**= $**

* Premium is charged per child, up to three (3) times the premium fee, after which no further premium is charged for additional children.
The cost of coverage includes medical insurance premium and administrative fees

4. COMPLETE DEPENDENT INFORMATION BELOW. THIS SECTION MUST BE COMPLETED FOR ENROLLMENT TO BE ACCEPTED. DEPENDENTS MAY BE ENROLLED IN THE PLAN ONLY IF THE STUDENT IS ALSO ENROLLED IN THE PLAN.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	GENDER
SPOUSE/DOMESTIC PARTNER				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE

DEPENDENTS MAY BE ENROLLED IN THE PLAN ONLY IF THE STUDENT IS ALSO ENROLLED IN THE PLAN. Dependents must be enrolled on the date the student enrolls or within 31 days of marriage, birth, adoption or placement for adoption, arrival in the U.S., or ineligibility under another creditable coverage.

Newly acquired dependents (spouse and/or children) are not subject to the enrollment deadline dates. However, enrollment and premium payment for all newly acquired dependents (spouse and/or children) must be submitted within 31 days of marriage, birth, adoption or placement for adoption, or arrival in the U.S. (Proof of date of arrival in the U.S., birth, adoption, or marriage may be requested). **Otherwise, enrollment cannot be accepted after the enrollment deadline dates.**

5. REMIT PAYMENT IN U.S. FUNDS ONLY. MAKE CHECK OR MONEY ORDER PAYABLE TO: RELATION INSURANCE SERVICES OR COMPLETE CREDIT CARD INFORMATION BELOW.

CREDIT CARD AUTHORIZATION: CHARGE WILL APPEAR AS "STUDENT HEALTH INSURANCE, RELATION" ON YOUR CREDIT CARD BILL.																
CREDIT CARD #																
NAME OF CARDHOLDER (PLEASE PRINT)									CHARGE AMOUNT:	$			EXPIRATION DATE _____/_____			
By signing below, I authorize my credit card to be charged the amount listed above for the coverage I have selected under the Maricopa Community Colleges International Student Health Insurance Plan.																
SIGNATURE OF CARDHOLDER																

6. STUDENT SIGNATURE:

I certify that I am enrolled at one of the Maricopa Community Colleges. By signing below, I acknowledge that I have read and understand the information contained in the Maricopa Community Colleges International Student Health Insurance Plan Policy and elect to enroll for the coverage specified above.

SIGNATURE_____ **DATE**_____

7. STUDENT MUST OBTAIN AN AUTHORIZED SIGNATURE FROM THE COLLEGE REPRESENTATIVE OFFICE.

_____

NAME OF AUTHORIZED REPRESENTATIVE

_____

SIGNATURE DATE

8. RETURN THIS FORM WITH PAYMENT TO: RELATION INSURANCE SERVICES, PO BOX 240042, LOS ANGELES CALIFORNIA 90024
MUST BE POSTMARKED BY THE APPLICABLE DEADLINE DATE.

If there are any discrepancies between this document and the Plan Certificate, the Plan Certificate will govern.