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125284-19

Rosalind Franklin University 2019 - 2020 Continuation Enrollment Form

STUDENTS AND THEIR DEPENDENTS

Students presently enrolled in Rosalind Franklin University's (RFU) Student Health Insurance Plan are eligible for Continuation of Coverage underwritten by Blue Cross and Blue Shield of Illinois. Continuation of Coverage is only available to Insured Students and covered Dependents who have graduated or are no longer eligible for coverage under the RFU Student Health Insurance Plan. Covered students must have been insured for at least three (3) continuous months before coverage terminated under the Prior and/or Current Plan.

The premium must be received within 30 days after the existing coverage under the RFU Student Health Insurance Plan terminates. The period of coverage must be specified on the next page and the total premium must be paid at the time of enrollment. There is no renewable option and no refunds are available after you have selected the coverage.

COVERAGE:
For a description of covered benefits, definitions, and exclusions, please refer to the 2019-2020 Student Health Insurance Plan brochure or to the Policy. Brochures are available online at **rosalindfranklin.myahpcare.com.**

(PLEASE PRINT CLEARLY or TYPE)

STUDENT INFORMATION									
Student Name	First		Middle Initial		Last				
Local & ID Card Mailing Address	Street or P.O.Box		City			State	Zip Code		
Termination Date of Current Insurance Coverage	(MM/DD/YYYY) / /		**Phone/Cell Number**	( ) —					
Email	*(A confirmation email will be sent upon enrollment)*								
Male		**Female**		**Date of Birth**	(MM/DD/YYYY) / /	**SSN**	- -	**Student ID Number**	*(must be provided to be processed)*

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must take place at the time of student enrollment, with the exception of newborn or adopted children or a qualifying event. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

DEPENDENT INFORMATION						
Dependent	**First Name**	**MI**	**Last Name**	**Date of Birth** (MM/DD/YYYY)	**Gender** (M/F)	**Social Security Number**
Spouse				/ /		– –
Child 1				/ /		– –
Child 2				/ /		– –
Child 3				/ /		– –

ENROLLMENT TERMS & CONDITIONS: Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Student meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and **4)** Other than entry into the Armed Forces, **the premium is not refundable**. It is the student's responsibility to make a timely renewal payment. This plan is underwritten by **Blue Cross and Blue Shield of Illinois**.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

SIGNATURE: _____ DATE: _____

(Signature of Student, or Parent if Student is under age 18)

Please note this enrollment form cannot be processed unless you make all your coverage selections on the next page. **CONTINUE ON NEXT PAGE →**

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STUDENTS AND THEIR DEPENDENTS

Student Name: _____ Student ID Number: _____

(must be provided to be processed)

The premium must be received within 30 days after the existing coverage under the RFU Student Health Insurance Plan terminates.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES

COVERAGE DATES	MONTHLY RATE (6 Month Maximum)		*CALCULATE TOTAL PREMIUM
	Coverage	Monthly Rate	Step 1 - Choose all desired premiums Step 2 - Write the amount chosen in the applicable column(s) below Step 3 - Calculate and submit total due
Day After SHIP Term Date _____ /_____ /_____ through _____ /_____ /_____	Student	$ 279.34	$ 279.34 X _____ # Months = _____
	Spouse	$ 279.34	$ 279.34 X _____ # Months = _____
	Child	$ 279.34	$ 279.34 X _____ # Months = _____
	Two or More Children	$ 558.68	$ 558.68 X _____ # Months = _____
		TOTAL	$
			*TOTAL PREMIUM TO BE PAID IN FULL

6 Months Maximum
Coverage may not extend past the termination date of 06/30/2020

Please Note: The Continuation Privilege will allow you to purchase coverage up to a maximum of **six (6) consecutive months**, your selection is final and non-renewable. Incorrect payment amounts will be returned and no coverage will be in effect.

Please use the chart above to calculate total amount due.

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received**. If you have questions, please call Academic HealthPlans at **1-855-844-3019.**

PAYMENT OPTIONS

If paying by credit card fax to **1-855-858-1964**		By check	
Amount to be charged	$	Make check or money order in U.S. dollars, payable to	Academic HealthPlans
Credit Card Number		Check Amount	$
Expiration Date	(MM/YY) /	Check Number	
Billing Zip Code		Mail check and this enrollment form to	Academic HealthPlans P.O. Box 1605 Colleyville, TX 76034-1605
VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐			

☐ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. I understand my insurance will be cancelled if my credit card is declined. All charges will show on my credit card statement as Academic HealthPlans, Inc.**

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____

I was a student at Rosalind Franklin University. I am presently insured under the RFU Student Health Insurance Plan and wish to enroll for Continuation of Coverage. I have read the brochure and elect to enroll myself and my dependent(s) as shown above.

STUDENT'S SIGNATURE: _____ DATE: _____