Academic HealthPlans

10608-19

University of Kentucky 2019-2020 Continuation Insurance Enrollment Form

STUDENTS AND THEIR DEPENDENTS

ELIGIBILITY: All Covered Individuals who have been continuously insured under the school's regular student Policy for at least **three (3) consecutive months** and who no longer meet the eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than 90 days under the school's Policy in effect.

Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous Student Health Insurance Plan and must be purchased within 31 days after the expiration date of your previous coverage. If premium is not received within 31 days, the premium will be refunded.

COVERAGE: For a description of covered benefits, definitions, and exclusions, please refer to the 2019-2020 Student Health Plan Policy. The Policy is available online at **uky.myahpcare.com.**

(PLEASE PRINT CLEARLY or TYPE)

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**	( ) —	
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	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 and cardholder 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.

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 OF CARDHOLDER: ______________________________ DATE: ______________

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

PRINTED NAME OF CARDHOLDER: ______________________________ DATE: ______________

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

ahp Academic HealthPlans™

10608-19

University of Kentucky 2019-2020 Continuation Insurance Enrollment Form

STUDENTS AND THEIR DEPENDENTS

Student Name: ______________________________ Student ID Number: ______________________
(must be provided to be processed)

The premium must be received within 31 days after the existing coverage under the University of Kentucky Student Health Plan terminates.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of three (3) consecutive months of coverage, your selection is final and non-renewable and cannot be purchased month to month. Incorrect payment amounts will be returned and no coverage will be in effect.

PERIOD RATES AND COVERAGE DATES			
COVERAGE DATES	**MONTHLY RATE**		***CALCULATE TOTAL PREMIUM**
Day After SHIP Term Date 08/15/2019 through ____/____/______ 3 Months Maximum	**Coverage**	**Monthly Rate**	**Example: $221 x 3 months = $663**
	Student	$ 221.00	$221 (Rate) X ______ (# Months) = $ ________ (Total)
	Spouse	$ 221.00	$221 (Rate) X ______ (# Months) = $ ________ (Total)
	Child	$ 221.00	$221 (Rate) X ______ (# Months) = $ ________ (Total)
	Children	$ 442.00	$442 (Rate) X ______ (# Months) = $ ________ (Total)
		TOTAL	$
	***TOTAL PREMIUM MUST BE PAID IN FULL**		

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 **1-855-856-2385**.

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.**

☐ **By continuing dependent enrollment, you confirm that you have read the eligibility requirements for dependents, that your dependent(s) is(are) eligible for coverage, and that you will submit documentation required to verify your dependent(s) eligibility. Documents should be submitted at time of enrollment with enrollment form or uploaded at UkyDependents@ahpservice.com. Failure to submit proof of eligibility will result in termination of coverage.**

SIGNATURE OF CARDHOLDER: ______________________________ DATE: ________________

PRINTED NAME OF CARDHOLDER: ______________________________ DATE: ________________

I was a student at University of Kentucky. I am presently insured under the UKY Student Health Insurance Plan and wish to enroll for Continuation Coverage. I have read the brochure and elect to enroll myself (and my Dependents, if applicable) as shown above.

STUDENT SIGNATURE: ______________________________ DATE: ________________
(Signature of Student, or Parent if Student is under age 18)