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2019-382-1

University of Louisville 2019-2020 Continuation Student Health Insurance Enrollment Form

STUDENTS AND THEIR DEPENDENTS

Students presently enrolled in University of Louisville (UofL) Student Health Insurance Plan are eligible for up to six (6) consecutive months Continuation of Coverage underwritten by UnitedHealthcare Insurance Company. Continuation of Coverage is only available to Insured Students and covered dependents who have graduated or are no longer eligible for coverage under the UofL 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.

Continuation of Coverage is in effect from the date coverage under the UofL Student Health Insurance Plan expires if the completed enrollment form and applicable premium are received within 30 days after the Covered Person's termination date, and continues until the end of the period for which premium is paid.

The enrollment form and total premium must be received within 30 days after the existing coverage under the UofL 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. 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 **louisville.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.

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare.

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: 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**. This plan is underwritten by **UnitedHealthcare Insurance Company.**

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 for consecutive months of Continuation Coverage must be received within 30 days of your coverage end date.

(PLEASE CHECK ALL THE APPROPRIATE BOXES)

PERIOD RATES AND COVERAGE DATES

REQUESTED EFFECTIVE DATES	
DAY AFTER SHIP TERM DATE	___/___/_____
REQUESTED TERMINATION DATE	___/___/_____
Coverage may not extend past the termination date of 07/31/2020	

MONTHLY RATE (6 Month Maximum)			CALCULATE MONTHLY RATE
Coverage	Monthly Rate		Example: $250 x 3 months + $15 = $765
Student		$ 250.00	$250 (Rate) X _____ (# Months) = $ _____ (Total)
Spouse		$ 250.00	$250 (Rate) X _____ (# Months) = $ _____ (Total)
Each Child		$ 250.00	$250 (Rate) X _____ (# Months) = $ _____ (Total)
All Children		$ 500.00	$500 (Rate) X _____ (# Months) = $ _____ (Total)
Processing Fee			$15.00
TOTAL			$

Please Note: The Continuation Privilege will allow you to purchase coverage up to a maximum of **six (6) consecutive months**. The final cost will include a $15 processing fee. Incorrect payment amounts will be returned and no coverage will be in effect.

PAYMENT INFORMATION. You can pay via credit card, money order or check (details are provided below). If you have questions, please call Academic HealthPlans at **1-855-850-4191**.

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 the University of Louisville. I am presently insured under the UofL 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'S SIGNATURE: _____ DATE: _____