UNIVERSITY OF
NORTHERN COLORADO

# National Guardian Life Insurance Company
# 2019-2020 Student Health Insurance Plan
# Optional Intercollegiate Sports
# Fall Enrollment Form

STUDENT HEALTH INSURANCE OFFICE
CASSIDY HALL – CAMPUS BOX 46
GREELEY, COLORADO 80639
(970) 351-1915 FAX: (970) 351-4726

| Enrollment Period | | Premium Amount | |
|---|---|---|---|
| ❑ Fall Semester | 08/01/2019 to 01/01/2020 | Student only | ❑ $ 835.00 |

The coverage periods are effective and will terminate at 12:01am on the dates advertised.

Student Name:_____ Bear#:_____

Date of Birth:_____ Gender: _____ Male _____ Female SSN#:_____

Address:_____
Street City State Zip

Telephone Number: (_____)_____ Sport:_____

Intercollegiate student athletes at the University of Northern Colorado may obtain this optional benefit to cover Injuries that occur while participating in an intercollegiate sport. This coverage is for Injuries only and requires an additional premium of $835.00 for Fall coverage. You must be enrolled in the University of Northern Colorado Student Health Insurance Plan to be eligible for this coverage.

To enroll, please provide the following information.

- A signed copy of this enrollment form
- Payment by cashier's check or money order payable to **National Guardian Life Insurance Company** or credit card to UNC in the amount of $835.00 for Fall coverage.
- Proof of player status on an official UNC intercollegiate sports team.

This benefit will be paid as any other covered Injury and a maximum payment of $5,000 per covered Injury.

| **PAYMENT OPTIONS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Charge Full Amount via Card** | $ | **Expiration Date** | ____/____ Month Year | | **Check made payable to** | ***National Guardian Life Insurance Company*** |
| | **Billing Address** | | | | | Check Amount | $ |
| VISA ❑ | MasterCard ❑ | Discover ❑ | AMEX ❑ | | | Check Number | |
| Credit Card Number | | | | | | | |

❑ 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 _____

Signature of Student: _____ DATE _____

For Office Use Only: Fax to AHP after approval 1-855-858-1964: _____

Date Entered:_____ Flag Changed:_____
Entered By:_____ Eligibility:_____ Update: _____
E-Mail Sent to Student:_____ Letter: _____
Benefits Book:_____ Medicat:_____ Scanned:_____ # of hours:_____

National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life