RUTGERS GRAD FELLOWS / PART-TIME TA/GAs
HEALTH INSURANCE ENROLLMENT/CHANGE FORM
GROUP POLICY #812813

(PLEASE PRINT)

Name_____
Last First MI

Mailing Address_____
Street or PO Box City State Zip

Rutgers University ID #_____ Date of Birth_____ Phone#_____ Gender:_____

REASON FOR ENROLLMENT
□ Annual open enrollment
□ Other (explain in "Remarks" section below)

REQUESTED EFFECTIVE DATE OF CHANGE:

____ /____/_____
mm dd yyyy

CHANGES TO EXISTING COVERAGE
□ Individual □ Family
□ Addition of a dependent
□ Change in application information
□ Termination of Coverage
□ Other (explain in "Remarks" section below)

REMARKS:

If you are enrolling Dependents, list Dependents to be insured below.
Dependent coverage is available ONLY if the student is also insured under the Plan.

	Last Name	First Name	MI	Date of Birth	SS#	Gender
Spouse:						
Child:						
Child:						
Child:						
Child:						

SPOUSE'S OTHER HEALTH INSURANCE (NAME OF CARRIER):_____
_____POLICY #_____

NOTE: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed and premium are sent, if later. Coverage for insured dependents terminates in accordance with termination provisions described in the Master policy.

PREMIUM RATES for the Period of January 1, 2009 – December 31, 2009

Student Only	$233.00 per Month
Student & One Dependent	$533.00 per Month
Student & Family (2 or more dependents)	$677.00 per Month

NOTICE: Coverage will be effective from the date the correct premium is received by the University or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded.

SIGNATURE:_____ DATE:_____

Please contact University Health Plans at info@univhealthplans.com or (800) 437-6448 if you have any questions about enrolling yourself or dependents in the plan.

- *Coverage is underwritten by: Aetna Life Insurance Company (ALIC)*

*ADMINISTRATION SIGNATURE*_____*TITLE:*_____*DATE:*_____