

**RUTGERS POST DOCTORATE, GRAD FELLOWS, TA'S & GA'S
CONTINUATION OF ENROLLMENT FORM FOR STUDENTS
AND THEIR DEPENDENTS**

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to purchase up to a maximum of 90 days, but not longer than the current plan year. Include full payment based on the coverage selected and the number of months chosen. Payment will not be accepted on a month-to-month basis. Incorrect payment amounts will be returned and no coverage will be in effect. If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (3 months of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. **Please select the amount of months carefully. You will not be allowed to purchase any additional months after your initial selection.**

Student's Name: _____ Date of Birth: _____ Rutgers ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

**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	Sex Assigned at Birth
Spouse: _____	_____	_____	_____	_____
Child: _____	_____	_____	_____	_____
Child: _____	_____	_____	_____	_____

Please check the period of coverage desired:

Period of Coverage	Student Only	Student Plus Spouse	Student Plus One Child	Student Plus Two or More Children	Student Plus Spouse and Two or More Children
1 Month – 2/1/20 – 2/29/20	_____ \$193.00	_____ \$386.00	_____ \$386.00	_____ \$579.00	_____ \$772.00
2 Months – 2/1/20 – 3/31/20	_____ \$386.00	_____ \$772.00	_____ \$772.00	_____ \$1158.00	_____ \$1544.00
3 Months – 2/1/20 – 4/30/20	_____ \$579.00	_____ \$1158.00	_____ \$1158.00	_____ \$1737.00	_____ \$2316.00

Make your check or money order for the total applicable premium listed above payable to **University Health Plans**. Please return this form and payment to:

**University Health Plans, Inc.
15 Pacella Park Drive, Suite 130
Randolph, MA 02368**

NOTICE TO STUDENT: By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 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. Premium will not be refunded except for ineligibility or entrance into the armed forces. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: _____ **DATE:** _____