RUTGERS BIOMEDICAL & HEALTH SCIENCES
CONTINUATION OF ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

Eligibility: 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 continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy 2019-527-1 is subject to the rates and benefits selected by the school for that policy year.

Student's Name_____Date of Birth:_____RBHS ID#: A00_____

Address:_____City:_____State:_____Zip:_____

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

	Last Name	First Name	MI	Date of Birth	Gender
Spouse:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____

Please check the period of coverage desired:

Period of Coverage	Student Only	Spouse	Each Child	2 or More Children	Spouse + 2 more Children
1 Month – 8/15/19 – 9/14/19	_____$193.00	_____ $193.00	_____ $193.00	_____$386.00	_____ $579.00
2 Months – 8/15/19 – 10/14/19	_____$386.00	_____ $386.00	_____ $386.00	_____$772.00	_____ $1,158.00
3 Months – 8/15/19 – 11/14/19	_____$579.00	_____ $579.00	_____ $579.00	_____$1,158.00	_____ $1,737.00

***PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 3 consecutive months, 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.**

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: Coverage is effective immediately following the expiration of the regular student plan and must be purchased within 31 days after the expiration date of your student coverage. If premium is not received within 31 days, the premium will be refunded. 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:**_____