**ST. MARY'S UNIVERSITY** **SDHN00575100-09**
**2009-2010 CONTINUATION OPTION**
**STUDENT HEALTH INSURANCE ENROLLMENT FORM**

Students ***presently enrolled*** in the St. Mary's University Student Health Insurance Plan are eligible for Continuation of Coverage underwritten by ACE American Insurance Company. Continuation of Coverage is ***only*** available to Insured Students who have graduated or are no longer eligible for coverage under the St. Mary's University Student Health Insurance Plan. Former Insured Students must have been insured for at least six continuous months before coverage terminated under the Prior and/or Current Plan. This Option is also available to Dependents of the Former Insured Student provided: (1) the Former Insured Student elects coverage under this Option; (2) Dependents were covered under the Prior and/or Current Plan on the date coverage would otherwise end; and Dependents enroll for the same period of coverage as the enrolled Former Insured Student. Newborn children born after the termination date of the Plan are ***not eligible*** for Continuation of Coverage.

Continuation of Coverage is in effect from the date coverage under the St. Mary's University Student Health Insurance Plan expires if the completed Enrollment Form and applicable premium are received prior to the Covered Person's termination date, and continues until the end of the period for which premium is paid. ***The premium must be received before the existing coverage under the St. Mary's University Student Health Insurance Plan terminates. In no event will the Covered Person be eligible for Continuation of Coverage, if premium is received after the termination date of the Policy. The period of coverage must be selected and the total premium must be paid at the time of enrollment. There is no renewable option, and no refunds are available.***

**COVERAGE:**
For a full description of covered benefits, definitions, and exclusions, please refer to the 2009-2010 Student Health Insurance Plan Brochure or to the Policy. Brochures are available by calling the Student Health Center at (210) 436-3506.

Student's Name: _____
First Middle Initial Last

Mailing Address: _____
Street or PO Box City State Zip Code

Email Address: _____
(A confirmation email will be sent upon enrollment)

Termination Date of Coverage Currently Held _____/_____ /_____ Telephone Number _____-_____-_____

Date of Birth _____/_____ /_____ ____ Male ____ Female SSN _____ - _____ - _____
M D Y

**Dependent Information:**

| | First Name | MI | Last Name | Date of Birth (M/D/Y) | Gender (M/F) | Social Security # |
|---|---|---|---|---|---|---|
| Spouse | | | | | | |
| Child | | | | | | |
| Child | | | | | | |

**PERIOD OF COVERAGE REQUESTED**

| **Coverage:** | **Six Months** |
|---|---|
| ❑ Domestic Student | ❑ $ 672.00 |
| ❑ International Student | ❑ $ 868.00 |
| ❑ Spouse | ❑ $1,700.00 |
| ❑ Each Child | ❑ $ 870.00 |

**PAYMENT INFORMATION**

CHECK # _____ CHECK AMOUNT $_____

**PREMIUM PAYMENT INSTRUCTIONS:** Make check or money order payable to **ACE American Insurance Company** in U.S. Dollars. Mail this completed Enrollment Form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605 prior to the termination date of your coverage.** Your cancelled check is your only receipt and notification of coverage.

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.

I am a student at St. Mary's University. I am presently insured under the 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 _____**
**(Signature of Student or Parent if Student is under age 18)**

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