

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
PACE UNIVERSITY

PROCESSOR STAMP DATE RECEIVED HERE

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2013-869-1

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: ____/____/____ MONTH DAY YEAR	
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

DEPENDENT INFORMATION: Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	

NOTICE TO STUDENT: Coverage is effective immediately following the expiration of the regular student plan and must be purchased within 14 days after the expiration date of your student coverage. If premium is not received within 14 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.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

STUDENT'S SIGNATURE: _____

DATE: _____

- New York City Campus
 Pleasantville Campus
 Law School / White Plains

CAMPUS/SCHOOL ATTENDING: _____

Please Print Name of University Must be completed in order for application to be processed.

I elect to purchase Injury and Sickness insurance coverage under the University’s student insurance plan. Below are the choices I have made.

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 the Policy are eligible to continue their coverage for a period of not more than three months under the school’s policy in effect. 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 is subject to the rates and benefits selected by the school for that Policy Year.

PLEASE CHECK ALL APPROPRIATE BOXES
INSURED CATEGORY: Full-Time Continuation

PERIOD CODES	Monthly (MX) 3 month maximum)
ID CODES	
7 Student	<input type="checkbox"/> \$ 204.00
8 Spouse	<input type="checkbox"/> \$ 573.00
9 Each Child	<input type="checkbox"/> \$ 518.00

PLEASE CHECK ALL APPROPRIATE BOXES
INSURED CATEGORY: Part-Time Continuation

PERIOD CODES	Monthly (MX) 3 month maximum)
ID CODES	
10 Student	<input type="checkbox"/> \$ 263.00
11 Spouse	<input type="checkbox"/> \$ 573.00
12 Each Child	<input type="checkbox"/> \$ 518.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school’s administrative costs associated with offering this health plan.

EFFECTIVE / EXPIRATION PERIODS:
 Continuation 08-15-2013 to 08-14-2014

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: \$204.00 x 3 months = \$612.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____
Multiply by # of months: _____
Total premium enclosed: \$ _____

*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. 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. Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 14 days after the expiration date of your previous continuation coverage. If premium is not received within 14 days, the premium will be refunded.

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment card along with premium payment to:
 UnitedHealthcare **StudentResources**
 PO Box 809026
 Dallas, TX 75380-9026.
 Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

To pay with a credit card: If you want to pay for your coverage with a credit card or eCheck, complete the required information above and mail this enrollment form to the address indicated. Make sure your email address is correct; we will enter your coverage request into our system and send you an email with instructions for making your premium payment online with a credit card or eCheck.