Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

LOYOLA UNIVERSITY CHICAGO **2016-1291-1**

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
SOCIAL SECURITY #:	STUDENT ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	EXPECTED DATE OF GRADUATION: (MONTH/YEAR)
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # 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/CIVIL UNION PARTNER SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:

NOTICE TO STUDENT: Continuation of Coverage is effective immediately following the expiration of Loyola University Chicago Student Health Insurance Plan, if the completed enrollment form and applicable premium are received within 31 days of the termination date. The Insured person will not be eligible to continue coverage if payment is received after the 31 day grace period, as the premium paid will be refunded and the coverage cancelled.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

Student's Signature: ____ Date: ______________

Campus/School Attending: Loyola University Chicago

☐ **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 6 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 6 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: ☐ Continuation

Period Codes		Monthly (MX) (6 months maximum)
ID Codes		
11	Student	☐ $ 242
12	Spouse/Civil Union Partner	☐ $ 242
13	One Child	☐ $ 242
14	Two or More Children	☐ $ 485
15	Spouse + Two or More Children	☐ $ 727

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/1/2016 to 7/31/2017

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $242.00 x 3 months = $726.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $_____

Multiply by # of months: _____

Total premium enclosed: $_____

*PLEASE NOTE: Continuation of coverage must initially be purchased **within the 31 day grace period upon expiration** of the Loyola University Chicago Student Health Insurance Plan. If a person chooses to pay for the continuation of coverage on a month-to-month basis, the applicable premium will need to be received within 10 days of termination of the initial month's coverage and for every month thereafter. If premium is received after the 10 day continuation grace period, your coverage will be cancelled and the premium refunded.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:
UnitedHealthcare **Student**Resources
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.