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

PACE UNIVERSITY **2016-869-1**

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.

SOCIAL SECURITY #:	OR 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 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: The Insured must enroll and pay the required premium within 60 days of the date coverage terminates under the regular student policy by reason of a qualifying event. Coverage will be effective on the date of the qualifying event provided the enrollment and premium payment is received within the 60 day enrollment and premium payment deadline. If premium is not received within 60 days, the premium will be refunded. By signing, the Insured acknowledges the following: 1) He/She has carefully read the certificate and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the Continuation of Coverage qualifying event eligibility requirements for this coverage as described in the certificate; and 4) If it is later determined that the Insured 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: ____________

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 and who no longer meet the Eligibility requirements under the Policy as a result of a qualifying event are eligible to continue their coverage under the school's policy in effect for the maximum period of coverage allowed, not to exceed 90 days, as specified in the Continuation of Coverage provision of the certificate. 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) (90 days maximum)
ID Codes		
11	Student	☐ $ 156.00
12	Spouse	☐ $ 156.00
13	One Child	☐ $ 156.00
14	Two or more Children	☐ $ 312.00
15	Spouse and 2 or more Children	☐ $ 468.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction, of your school.

EFFECTIVE/EXPIRATION PERIODS:
☐ Annual 8/15/2016 to 8/14/2017

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due Example: $156.00 x 3 months = $468.00

CALCULATION FOR MONTHLY PREMIUM:

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

*PLEASE NOTE: The Continuation of Coverage will allow you to purchase up to a maximum of 90 days, 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 coverage (90 days of coverage less any 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 30 days after the expiration date of your previous continuation coverage. If premium is not received within 30 days, the premium will be 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 is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.