SAINT LOUIS UNIVERSITY

ELECTION OF STUDENT CONTINUATION COVERAGE FORM

For Student Continuation Coverage periods beginning July 1, 2016 – June 30, 2017

Student Continuation Coverage is a temporary extension of coverage under the University Health Plan (UHP). Student Continuation Coverage becomes available when UHP eligibility would otherwise end for a Saint Louis University student. Events such as graduation, approval of withdrawal, death or divorce or legal separation from a participant are examples of when Student Continuation Coverage may become available. Student Continuation Coverage may also be available to dependents. Student Continuation Coverage, if elected, is the same coverage provided to other similarly situated covered individuals who are not receiving Student Continuation Coverage. All accumulated lifetime and annual maximums as provided in the plan will apply.

Based on the student's election, the length of Student Continuation Coverage shall be three or six months from the date a covered individual no longer meets eligibility requirements. To be enrolled for Student Continuation Coverage, one must:

1. submit to the University Health Plan this completed notice and provide payment for the Student Continuation Coverage within 60 days after the date you lose eligibility under the plan; and
2. submit any supporting documentation that may be requested by the University Health Plan; and
3. be in good standing with Saint Louis University; and
4. not meet any eligibility requirements.

STUDENTS MUST ELECT/SELECT EITHER 3 OR 6 MONTHS OF COVERAGE.
ONCE THE PERIOD OF COVERAGE IS SELECTED AND PAID FOR, THE SELECTION MAY NOT BE ALTERED OR MODIFIED.
STUDENTS MUST PROVIDE FULL PAYMENT FOR THE PERIOD OF CONTINUATION COVERAGE SELECTED.
NO REFUNDS SHALL BE MADE AFTER PAYMENT IS SUBMITTED.

Direct all documentation and payments related to Student Continuation Coverage to:

University Health Plan – Saint Louis University
1402 S. Grand Blvd, C119
St. Louis, MO 63104 or Fax: 314-977-5667

I understand the terms noted above, specifically that NO REFUNDS NOR ELECTION CHANGES are allowed, and wish to continue my coverage as indicated on the enrollment form:

Yes______ No_______

I understand the terms noted above, specifically that NO REFUNDS NOR ELECTION CHANGES are allowed, and wish to continue my dependent(s) coverage as indicated on the enrollment form:

Yes______ No_______ N/A______

Print Name ________________________ Birthdate ___________ Banner ID # ___________
Signature __________________________ Current Date ___________
Phone Number ______________________ Email Address __________________
Street Address _____________________ Apt/Unit-Mailbox # ___________ City _____________ State ________ Zip ________

(Enter your address that will be in effect during the period of Student Continuation Coverage.)

Revised: 07/15/16
Aetna Life Insurance Company
Aetna Student Health
Saint Louis University – 3 & 6 Month Continuation Plan – Undergraduate, Graduate Professional & Medical Students and Dependents Insurance Plan
2016/2017 Student Health Insurance Enrollment Form
In order to enroll you must complete steps 1 through 4!

1. **Complete all Student information. Incomplete information will delay processing! Contact University Health Plan at 314-977-5666 for assistance.**

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Student Name: 

Last Name: 
First Name: 
MI: 

Student ID #: 

Email address: 

Mailing Address: 
This address will be used for all Aetna Student Health insurance communications

City: 
State: 
Zip Code: 

Phone Number: 

Date of Birth: mm/dd/yy

Sex: Male  Female

2. **List Dependents to be insured. Dependent coverage is only available if the student is covered.**

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>Social Security Number</th>
<th>M/F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
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<td>Child</td>
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</table>

3. **Select Enrollment Plan**

Form ID: 867936-C19

<table>
<thead>
<tr>
<th>3 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date:</strong></td>
<td><strong>Effective Date:</strong></td>
</tr>
<tr>
<td><strong>Termination Date:</strong></td>
<td><strong>Termination Date:</strong></td>
</tr>
</tbody>
</table>

1. Student Only: ☐ $1,122 ☐ $2,244
2. Double: ☐ $2,244 ☐ $4,488
3. Family: ☐ $3,366 ☐ $6,732

**Total**

* Enrollment will not exceed plan termination date of 8/14/2017; premium will be remitted to SLU.
4. **Notice to Student (Signature required)**

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. I **permit Saint Louis University to provide Aetna Student Health with enrollment status for purposes of eligibility under this plan.** I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) can be made void. I understand that if it is later determined that I am not eligible (see the Plan Design and Benefits Summary) the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

It is the student's responsibility for timely payments.

*Enrollment Guidelines: For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage.*

*Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company. Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Health® is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).*

Signature: ________________________________ Date: ________________________________

Please send to: UHP Office - Fax # 314-977-5667
SAINT LOUIS UNIVERSITY

UHP - PAYMENT RECEIPT
STUDENT CONTINUATION COVERAGE

Banner ID #: 
Name: 

☐ $1,122 3 Mth SINGLE  ☐ $2,244 6 Mth SINGLE
☐ $2,244 3 Mth DOUBLE  ☐ $4,488 6 Mth DOUBLE
☐ $3,366 3 Mth FAMILY  ☐ $6,732 6 Mth FAMILY

Amount (Check one):

Route Payments to: University Health Plan – Saint Louis University
1402 S. Grand Blvd, C119
St. Louis, MO 63104 or Fax: 314-977-5667

Method of Payment: ☐ Check (Make checks payable to: University Health Plan)

☐ Credit Card - Visa
☐ Credit Card - Master Card
☐ Credit Card - American Express
☐ Credit Card - Discover

Credit Card Number: 
Expiration Date: 
Name on Card: 
Credit Card Billing Address:
Credit Card Billing City, State: 
Credit Card Billing Zip: 

I agree to pay amount noted above according to card issuer agreement:

Signature: 
Date: 

Revised: 07/15/16