BlueCross BlueShield of Texas

SOUTHERN METHODIST UNIVERSITY

101227-14

CONTINUATION INSURANCE ENROLLMENT FORM
2014–2015 Student Health Insurance Plan

Students **presently enrolle**d in Southern Methodist University (SMU) Student Health Insurance Plan are eligible for Continuation of Coverage underwritten by Blue Cross and Blue Shield of Texas. Continuation of Coverage is **only** available to Insured Students who have graduated or are no longer eligible for coverage under the Southern Methodist University (SMU) Student Health Insurance Plan. Covered students must have been insured for at least **three (3)** continuous months before coverage terminated under the Prior and/or Current Plan. This Option is also available to Dependents of the covered student provided: **(1)** the covered 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 **(3)** Dependents enroll for the same period of coverage as the enrolled covered student.

Continuation of Coverage is in effect from the date coverage under the Southern Methodist University (SMU) 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 Southern Methodist University (SMU) Student Health Insurance Plan terminates. Coverage may be purchased for the period of coverage below. 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 specified on the next page and the total premium must be paid at the time of enrollment. There is no renewable option and no refunds are available after you have selected the coverage.

COVERAGE:

For a description of covered benefits, definitions, and exclusions, please refer to the 2014–2015 Student Health Insurance Plan brochure or to the Policy. Brochures are available online at **smu.myahpcare.com.**

(PLEASE PRINT CLEARLY or TYPE)

Student's Name	First		Middle Initial		Last	
ID Card Mailing Address	Street or P.O.Box		City		State	Zip Code
Termination Date of Coverage Currently Held	(Month/Day/Year) / /		**Telephone Number** ( ) —			
Email *(A confirmation email will be sent upon enrollment).*			**Cell Number** ( ) —			
Male	**Female**	**Date of Birth** (Month/Day/Year) / /	**SSN** — —	**School ID Number** *(must be provided to be processed)*		

List Dependents to be insured below. Dependent enrollment must take place at the time of student enrollment, with the exception of newborn or adopted children or a Qualifying Event. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; therefore, will expire concurrently with that of the student.

	First Name	MI	Last Name	Date of Birth (M/D/Y)	Gender (M/F)	Social Security Number
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date the correct payment is received by the Company or an authorized representative of the Company, or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Student meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the payment will be returned; and **4)** Other than eligibility or entry into the Armed Forces, **the payment is not refundable**. **This plan is underwritten by Blue Cross and Blue Shield of Texas.**

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

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.

STUDENT'S SIGNATURE: _____ DATE: _____
(Signature of Student or Parent if Student is under age 18)

CARDHOLDER'S SIGNATURE: _____ DATE: _____

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side

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Student Name_____ **School ID Number**_____
(must be provided to be processed)

The premium must be received before the existing coverage under the Blue Cross and Blue Shield of Texas Health Insurance Plan terminates.

PLEASE CHECK THE APPROPRIATE BOX:

Period of Coverage Requested: Effective Date: _____ Termination Date _____

PREMIUM COST			
Coverage:	**Six Months**		
Student		$	2,256.00
Spouse		$	5,740.00
Each Child		$	1,299.00
Total Amount Due:	$		

Please check the appropriate box:		
Do you have other insurance?		**Yes**
		No
If yes, Insurance Company Name		
Policy Number		

Please attach a copy of your current Insurance ID card.

Please Note: The Continuation Privilege will allow you to purchase a maximum of **six (6) consecutive months** of coverage. Incorrect payment amounts will be returned and no coverage will be in effect.

The final cost will include a $15 processing fee. Please use the chart below to calculate total amount due.

CALCULATE TOTAL PREMIUM DUE

Step 1 - Choose all desired premium above **| Step 2 -** Write the amount chosen in the applicable column(s) below **Step 3 -** Calculate and submit total due.

Example: Student Rate + Spouse Rate + Processing Fee = Total
($2,256 + $5,740 + $15 = $8,011)

Student Rate	Spouse Rate	Each Child Rate	Each Child Rate	Processing Fee	Total Amount Due
$	+ $	+ $	+ $	+ $15.00	= $

PAYMENT INFORMATION: Make check or money order payable to **Blue Cross and Blue Shield of Texas** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605 or fax to (817) 809-4701, if paying by credit card.** If you have questions, please call Academic HealthPlans at (855) 357-0242. Your cancelled check or credit card billing is your only receipt and notification of coverage.

PAYMENT OPTIONS							
Charge Full Amount		$				Check Amount	$
	VISA		MasterCard		Discover	Check Number	
Credit Card Number						Expiration Date	_____/_____ Month Year

❑ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. I understand my insurance will be cancelled if my credit card is declined. All charges will show on my credit card statement as Academic HealthPlans, Inc.**

SIGNATURE OF CARDHOLDER: _____ DATE: _____

PRINTED NAME OF CARDHOLDER: _____ DATE: _____

I was a student at the Southern Methodist University. I am presently insured under the SMU 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)

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Academic HealthPlans, Inc. (AHP) is a separate company that provides program management and administrative services for the student health plans of Blue Cross and Blue Shield of Texas.