**PACIFIC UNIVERSITY** **SDHN000057501A-08**

**2008-2009 STUDENT HEALTH INSURANCE**

**FORMER INSURED STUDENT ENROLLMENT FORM**

Students ***presently enrolled*** in the Pacific University Student Health Insurance Plan are eligible for this coverage underwritten by **ACE American Insurance Company.** This coverage is ***only*** available to insured Students who have graduated or are no longer eligible for coverage under the Pacific University Student Health Insurance Plan. Former Insured Students must have been insured for at least six continuous months before coverage terminated under the Prior and/or Current Plan. This coverage is also available to Dependents of the Former Insured Students provided: (1) the Former Insured 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 Dependents enroll for the same period of coverage as the enrolled Former Insured Student. Newborn children born after the termination date of the Plan are ***not eligible*** for this coverage. This coverage is in effect from the date coverage under the Pacific University 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 Pacific University 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 selected, and the total premium must be paid, at the time of enrollment. There is no renewable option, and no refunds are available.***

**COVERAGE:**

For a full description of covered benefits, definitions, and exclusions, please refer to the 2008-2009 Student Health Insurance Plan Brochure or to the Policy. Brochures are available by calling the Student Health Center at (503) 352-2269.

Student's Name: ______________________________________________
First Middle Initial Last

Mailing Address: ______________________________________________
Street or PO Box City State Zip Code

Email ____________________________________ Telephone Number _______-________-________
(A confirmation email will be sent upon enrollment.)

Date of Birth ________/________ /________ ____ Male ____ Female Cell Number __________-_________-__________
M D Y

Student I.D.__________________________________ SSN _____________ - ___________ - ____________

**Dependent Information:**

| | First Name | MI | Last Name | Date of Birth (M/D/Y) | Gender (M/F) | Social Security # |
|---|---|---|---|---|---|---|
| Spouse | ________________ | _____ | ________________ | ____________ | ________ | _______-_____-_______ |
| Child | ________________ | _____ | ________________ | ____________ | ________ | _______-_____-_______ |
| Child | ________________ | _____ | ________________ | ____________ | ________ | _______-_____-_______ |

**PERIOD OF COVERAGE REQUESTED**

| Coverage: | Three Months | Six Months |
|---|---|---|
| ❑ Student | ❑ $414.00 | ❑ $ 827.00 |
| ❑ Spouse | ❑ $813.00 | ❑ $1,625.00 |
| ❑ Each Child | ❑ $401.00 | ❑ $ 801.00 |

**PAYMENT INFORMATION**

CHECK # _____________ CHECK AMOUNT $_____________

**PREMIUM PAYMENT INSTRUCTIONS:** Make check or money order payable to **ACE American Insurance Company** in U.S. Dollars. Mail this completed Enrollment Form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605 Prior to the termination date of your coverage.** Your cancelled check is your only receipt and notification of coverage.

**Warning:** 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, may be subject to prosecution for insurance fraud.

I am presently insured under the University 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)**

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