



Dear Student,

Thank you for your interest in the **2021-2022 Louisiana State University – HSC Shreveport Continuation Plan for students previously insured in the Student Injury and Sickness Insurance Plan Hard Waiver Program**. A Description of Benefits and enrollment form is enclosed for your review. This plan is underwritten by UnitedHealthcare Insurance Company and is serviced by Gallagher Student Health & Special Risk. UnitedHealthcare **StudentResources** is the Claims Administrator.

There are a few key provisions we would like to bring to your attention:

1. Please review the eligibility section thoroughly to ensure you are eligible to enroll.
2. The enrollment form **must be received within 15 days of termination of coverage under the LSU Student Injury and Sickness Insurance Plan**. Your coverage effective date will be retroactive to the day following your termination date under the Student Injury and Sickness Insurance Plan. If the deadline is not met, you will not be able to enroll in the Continuation Plan.
3. Students are allowed to purchase up to six (6) months of coverage and must select the term of coverage at the time of their initial enrollment. However, once the period of coverage the student elects terminates, they will not be eligible to re-enroll for another term of coverage.
4. The Continuation Plan duplicates the coverage of your current Student Injury and Sickness Insurance Plan.
5. Students will receive a new identification card. The Continuation Plan includes health care providers affiliated with the UnitedHealthcare Choice Plus PPO Preferred Provider Network. You can locate Choice Plus PPO providers at www.gallagherstudent.com/lsu-hscshreveport under “Find A Doctor”.
6. You must be eligible to enroll in the Continuation Plan and meet the enrollment deadline in order for your application to be accepted by us. If it is discovered you do not meet the requirements, your premium will be refunded.
7. This Continuation Plan does not require Pre-Certification to access Benefits.
8. Enrolling in the Continuation Plan does not guarantee additional benefits for a covered Injury or Sickness. Covered Medical Expenses incurred while enrolled in the active Student Injury and Sickness Insurance Plan prior to the Effective Date of coverage for the Continuation Plan will be applied towards the unlimited Per Injury and Sickness Plan Maximum.
9. The completed application along with the required premium should be sent to Gallagher Student Health & Special Risk, P.O. Box 845663, Boston, MA 02284-5663 or email Quincy.BSD.enrollmentteam@AJG.com.

Once Gallagher Student Health & Special Risk receives your completed enrollment form and applicable premium, we will process the application and send your information to the Claims Administrator.

If you have any questions, please contact us at 1-844-329-1589.

Sincerely,

Client Services

Gallagher Student Health & Special Risk

www.gallagherstudent.com/LSU-HSCShreveport



**Louisiana State University – HSC Shreveport
The UnitedHealthCare Insurance Company
2021-2022 Continuation Plan Enrollment Form**

Student's Last Name		First Name	Initial	Student ID #
Street Address		City	State	Zip Code
Email		Gender (male/female)		Date of Birth (mm/dd/yyyy)

Eligibility Requirement: All Insured Persons who have been continuously insured under the school's regular student policy for at least 12 consecutive months and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect at the time of such continuation. 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.

Calculate Your Premium

You must decide at the time of enrollment the period of coverage to purchase. You cannot re-enroll in the Continuation Plan after your Period of Coverage has expired. Enrollment in this Continuation Plan must be made within **15 days** from the date that coverage terminates under the student's active Student Injury and Sickness Insurance Plan. You must be eligible to enroll in the plan and meet the enrollment deadline in order for your enrollment to be accepted by us. If it is discovered you do not meet the requirements your premium will be refunded. Use the chart below to calculate the number of months you wish to continue coverage for yourself and your dependents. Add the amounts in the Total Premium Column to confirm total payment.

	Monthly Rate	x	Number of Months (6 maximum)	=	Total Premium
Student Only	\$226.83				
Spouse	\$226.83				
One Child	\$226.83				
Two or More Children	\$453.66				
Spouse and Two or More Children	\$680.49				
				Processing fee:	\$15.00
				Total Payment Enclosed:	

Continuation coverage for dependents must be purchased at the same time of student enrollment. Dependents can be enrolled only if, (a) they were previously enrolled under the active Student Injury and Sickness Insurance Plan, (b) the student enrolls in the Continuation Plan and (c) they are enrolled for the same period of coverage as the enrolled student. **List Dependents to be insured below**

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)
_____	_____	_____
_____	_____	_____

Notice to student: By signing below, the student acknowledges the following: 1) He/She elects to continue coverage for the number of months as indicated above; 2) Continuation coverage can only be purchased for a maximum of three (3) continuous months and is non-renewable; and 3) If it is later determined that the eligibility or enrollment requirements have not been met, coverage will be terminated and the premium will be refunded.

Signature of Student: _____ Date: _____

PAYMENT INSTRUCTIONS:

Charge to my (check one): Visa Master Card

Card Number: _____ Amount Charged: \$ _____ Expiration Date: _____

Name and Address of Card holder _____

Check or money order (International checks are not accepted). Make check or money order payable to **Gallagher Student Health & Special Risk.**

Mail, fax or email the enrollment form along with premium payment to: **Gallagher Student Health & Special Risk, P.O. Box 845663, Boston MA 02284-5663 / Email: Quincy.BSD.enrollmentteam@AJG.com**