Gallagher | STUDENT HEALTH & SPECIAL RISK

Dear Student,

Thank you for your interest in the **2014-2015 University of West Florida Continuation Plan for students previously insured in the Student Injury and Sickness Insurance Plan – Mandated International 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 your termination date under the UWF Injury and Sickness 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 three (3) 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/UWF under "Find a
6. Doctor".
7. 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.
8. This Continuation Plan does not require Pre-Certification to access Benefits.
9. 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.
10. The completed application along with the required premium should be sent to Gallagher Health & Special Risk, P.O. Box 845663, Boston, MA 02284-5663.

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 determine that the Continuation Plan does not meet your coverage needs, please contact us at 1-877-540-7407or by email at UWFStudent@gallagherstudent.com for other available insurance options.

Sincerely,

Client Services
Health & Special Risk
www.gallagherstudent.com/uwf

Gallagher | STUDENT HEALTH & SPECIAL RISK

University of West Florida
The UnitedHealthCare Insurance Company
2014-2015 Continuation Plan Enrollment Form – Mandated International Plan

Student's Last Name _____ First Name _____ Initial _____ Student ID # _____

Street Address _____ City _____ State _____ Zip Code _____ (_____)_____ Telephone Number

Email _____ Gender (male/female) _____ Date of Birth (mm/dd/yyyy) _____

Eligibility Requirement: All International students, including Visiting Scholars and Optional Practical Training students who no longer meet the eligibility requirements for the Mandated International Plan, but have been continuously insured under the school's student policy for at least one semester are eligible to continue their coverage for a period of not more than three (3) 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 (3 maximum)	= Total Premium
Student Only	$380		
Spouse	$584		
Each Child	$250		
		Processing fee:	$10.00
		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 or fax enrollment form along with premium payment to: **Gallagher Student Health & Special Risk, P.O. Box 845663, Boston MA 02284-5663 Fax: 617-479-0860**

Please include a $10.00 Processing Fee for credit card payments only.