

The University of Notre Dame Alliance for Catholic Education
2008-2009 Student Group Health Plan Continuation Enrollment Form
In order to enroll, you must complete steps 1 through 3 (Incomplete information may delay processing)

1. Complete all Student information.

Student Name: _____
Last Name First Name MI

Student ID# _____ Email address: _____

Permanent US Address

Street: _____
Apt. #

City: _____ State: _____ Zip Code: _____

Phone Number: () _____ Date of Birth _____ Sex: Male Female
mm/dd/yyyy

2. Termination Date, Other Coverage, and Premium.

PLEASE PROVIDE THE DATE YOUR CURRENT STUDENT COVERAGE WILL TERMINATE: _____

ARE YOU ELIGIBLE FOR OTHER HEALTH INSURANCE COVERAGE (INCLUDING MEDICARE)?: Yes No

PLEASE NOTE THAT THE FOLLOWING PREMIUM AMOUNT WILL BE DUE MONTHLY AND THAT THE FIRST MONTH'S PREMIUM MUST ACCOMPANY THIS APPLICATION:

	Monthly Continuation Amount for: June 1, 2008 – May 31, 2009
Former ACE Student	\$139.00

3. Notice to Student (Signature required)

Eligibility: All Students who (1) were covered under The University of Notre Dame Alliance for Catholic Education Student Group Health Plan; (2) no longer meet the eligibility requirements under The University of Notre Dame Alliance for Catholic Education Student Group Health Plan; and, (3) who are not eligible for other insurance coverage (including Medicare) are eligible to continue their Student Group Health Plan.

The maximum length of coverage under the continuation plan is six (6) consecutive months.

Students must note that they are responsible for the above premium payment and the first month's premium payment must accompany the initial application. Coverage does not extend beyond May 31, 2009 at the rates listed above. For coverage beyond May 31, 2009 a new application with new rates must be completed. An application can be obtained by contacting The ACE Program.

Coverage will be effective to coincide with the expiration of your student group health plan, provided this application and correct premium is received within 31 days after the expiration of your student coverage. Applications received after the 31 days will be returned and coverage will not be in effect. By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described above; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than eligibility, *the premium is not refundable.*

The information contained on this form is confidential and will not be released unless the student named in this form provides written authorization, except to comply with state or federal law or a court order. This information may also be released in the event of an emergency hospitalization, or in other circumstances, which pose a threat to life or serious immediate physical harm.

SIGNATURE: _____ DATE: _____