NOTICE OF ELECTION OF STUDENT CONTINUATION COVERAGE FORM

For Student Continuation Coverage periods beginning July 1, 2012 – June 30, 2013

Student Continuation Coverage is a temporary extension of coverage under the University Health Plan (UHP). Student Continuation Coverage becomes available when UHP eligibility would otherwise end for a Saint Louis University student. Events such as graduation, approval of withdrawal, approval of a leave of absence, death or divorce or legal separation from a participant are examples of when Student Continuation Coverage may become available. At the discretion of the Medical Director of the plan, Student Continuation Coverage may also be available to dependents. Student Continuation Coverage, if elected, is the same coverage provided to other similarly situated covered individuals who are not receiving Student Continuation Coverage. All accumulated lifetime and annual maximums as provided in the plan will apply.

The length of Student Continuation Coverage *shall not exceed six months* from the date a covered individual no longer meets eligibility requirements. To be enrolled for Student Continuation Coverage, you must:

1. **submit to the University Health Plan this completed notice** and **provide payment** for the Student Continuation Coverage within **60 days after the date you lose eligibility under the plan**; and
2. submit any supporting documentation such as an approved Change of Registration form or an approved Request for Leave of Absence form as requested by the University Health Plan; and
3. be in good standing with Saint Louis University; and
4. not be eligible for COBRA continuation coverage; and
5. not meet any eligibility requirements outlined in the plan's Summary Plan Description Section II.

Students losing UHP* eligibility *(i.e. due to graduation, withdrawal or change from full-time to part-time status) and NOT returning as full-time students within the next academic semester must provide full payment for the six months of Student Continuation Coverage. If such student subsequently enrolls in another health insurance plan as the result of a significant change in employment status including commencement of employment or change from part-time to full-time status, early termination of Student Continuation Coverage and an applicable refund may be requested. To request early termination, documentation supporting the change in employment status and related new coverage effective dates must be submitted to the University Health Plan within **31 days** of the change in employment status.

Students temporarily losing UHP* eligibility *(i.e. due to leave of absence) and returning as full-time student for the next academic semester (as evidenced by applicable student fees or registration status) may provide an initial payment for coverage from the date the student is no longer eligible to the start date of the next applicable Open Enrollment Period. Coverage may be extended past the start date of the next applicable Open Enrollment Period by making subsequent monthly payments to the Plan Administrator. However, the total length of Student Continuation Coverage cannot exceed six months. Subsequent monthly payments are due on the first of each month with a grace period of 30 days for each payment. You will not be billed for such payment by the Plan. It is your responsibility to make sure payments are submitted in a timely manner.

Student Continuation Coverage Rates: SINGLE: $1,842 / 6 mths DOUBLE: $3,588 / 6 mths FAMILY: $5,058 / 6 mths

Direct all documentation and payments related to Student Continuation Coverage to:

University Health Plan – Saint Louis University
1402 S. Grand Blvd, C119
St. Louis, MO 63104 or Fax: 314-977-5667

I understand the terms noted above and wish to continue my coverage: Yes_____ No_____

I understand the terms noted above and wish to continue my dependent(s) coverage: Yes_____ No_____ N/A_____

Coverage Period (check one): ☐ Six Months (NOT returning full-time) ☐ Until Next Open Enrollment (returning full-time)

_____ _____/_____/_____ _____
Print Name Birthdate Banner ID #

_____ _____/_____/_____
Signature Current Date

_____ _____
Phone Number Email Address

_____ _____ _____ _____
Street Address Apt/Unit/Mailbox # City State Zip

(Enter your address that will be in effect during the period of Student Continuation Coverage.)

Revised: 08/09/12