UNIVERSITY OF
NORTHERN COLORADO

National Guardian Life Insurance Company
2019-2020 Student Health Insurance Plan
Spring and Summer Re-Enrollment Form

ENROLLMENT PERIOD:
- ❑ Spring/Summer Semester 2020
- ❑ Summer Session 2020

STUDENT HEALTH INSURANCE OFFICE
CASSIDY HALL – CAMPUS BOX 46
GREELEY, COLORADO 80639
(970) 351-1915 FAX: (970) 351-4726

Student Name:_____ Bear#:_____

Date of Birth:_____ Gender: _____ Male _____ Female SSN#: _____

Address:_____
Street City State Zip

Telephone Number: (_____)_____ Email Address:_____

Eligibility Requirement: All students enrolled in at least nine (9) credit hours for undergrads and six (6) credit hours for graduate students and all international students are eligible to participate in this plan by completing this form.

I request re-enrollment in the UNC Student Health Insurance Plan after having submitted a "Request for Exemption for Student Health Insurance" form.

I understand that the provisions and exclusions of the UNC Student Health Insurance Policy apply to me.

I understand that if coverage is requested during the semester (not at the beginning of the semester), I will be required to document proof that I became ineligible for coverage under an employer-sponsored group Health insurance plan in the 31 days immediately preceding submitting my enrollment form for coverage under the UNC Plan.

I understand I will be billed $ 1310.00 for the insurance coverage and it will be in effect beginning 01/01/2020 and ending 08/17/2020 (include dates of semester). The coverage periods are effective and will terminate at 12:01am on the dates advertised.

I understand that if a re-enrollment is granted, I will be required to participate in the program for the remainder of the Policy Year while enrolled for 9 credit hours for undergrads and 6 credit hours for graduate students.

I understand that the Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium.

I understand my information is protected by privacy laws and will be released only in accordance with these laws. My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me the terms and conditions stated therein.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

_____ _____
Signature of Student Date

For Office Use Only: Comments: _____

_____

_____

Date Entered:_____ Flag Changed:_____
Entered By:_____ Eligibility:_____ Update: _____
E-Mail Sent to Student:_____ Letter: _____
Benefits Book:_____ Medicat:_____ Scanned:_____ # of hours:_____