**Aetna Life Insurance Company** | **The Chickering Group, An Aetna Company**
**Claims Administrator**

# Ross University-Continuation Plan
# 2007/2008 Student Health Insurance Enrollment Form

*In order to enroll you must complete steps 1 through 5!*

1. ***Complete all Student information. Incomplete information will delay processing! Contact The Chickering Group at 877-381-3551 for assistance.***

**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**

Student Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ ☐
Last Name First Name MI

Student ID/Social Security Number: ☐☐☐☐☐☐☐☐☐

Email address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ : ☐☐☐☐☐☐
This address will be used for all Chickering insurance communications Apt.#

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ Zip Code: ☐☐☐☐☐

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐ Sex: ☐ Male ☐ Female
mm/dd/yy

***2. List Dependents to be insured. Dependent coverage is only available if the student is covered.***

| Dependents | Last Name | First Name | DOB | Social Security Number | M/F |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

3. ***Select Enrollment Plan***

| **Form ID: 474883-C10** | **A.** | **B.** |
|---|---|---|
| **Continuation Plan** | **8 Month Coverage Period: 1/1/08-8/31/08 Enrollment Deadline: February 1, 2008** | **4 Month Coverage Period: 5/1/08-8/31/08 Enrollment Deadline: June 1, 2008** |
| 1.Student Under Age 30 | ☐ **$391** | ☐ **$195** |
| 2. Student Age 30-39 | ☐ **$449** | ☐ **$225** |
| 3. Student Age 40-49 | ☐ **$671** | ☐ **$336** |
| 4. Student Age 50 or Older | ☐ **$835** | ☐ **$417** |
| 5. Spouse Under Age 30 | ☐ **$1,280** | ☐ **$640** |
| 6. Spouse Age 30 or Older | ☐ **$1,672** | ☐ **$836** |
| 7. All Children | ☐ **$645** | ☐ **$322** |

**PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM.**
**APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.**
**WITHOUT YOUR SIGNATURE, WE WILL NOT ACCEPT YOUR ENROLLMENT APPLICATION. →**

***4. Designate Payment Method.***

**Make check or money order payable to Chickering Benefit Planning Insurance Agency Inc. Refer to the charge card authorization to charge premium to Visa or MasterCard (please note Visa and MasterCard are the only credit cards accepted). CASH WILL NOT BE ACCEPTED.**

**CREDIT CARD AUTHORIZATION-PLEASE PRINT CLEARLY!!! (VISA OR MASTERCARD ARE THE ONLY ACCEPTED CREDIT CARDS)Charge full amount: $☐☐☐☐.☐☐**

**Credit Card#(Visa or MasterCard only):** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp. Date:** ☐☐/☐☐

**Signature of Cardholder:**_____

**Printed Name and Address(if different from student):**

***5. Notice to Student (Signature required)***

Students presently enrolled in the Ross University Student Health Insurance Plan are eligible to continue their coverage by enrolling in the Ross University Continuation Plan. This Continuation Plan is only available to insured students who lose their eligibility for the Ross University Student Health Insurance Plan through graduation or otherwise leaving school. This Plan will be available to terminating students and eligible dependents as long as they were enrolled in Ross University Student Health Insurance Plan for the previous academic term. Newborn children born after the termination date of the 2006/07 Plan are not eligible for Continuation Coverage. Students eligible for the 2007/08 Ross University Student Health Insurance Plan are not eligible to purchase this Continuation Option. **To enroll, complete the enrollment form and remit the appropriate premium prior to the stated deadline date.** Coverage will be in effect the day after the termination date of your Ross University Student Health Insurance to insure continuous coverage**.** Application and premium received after deadline date will not be accepted and premium will be refunded.

Coverage may be purchased for a four (4), or eight (8) month Period of Coverage. The period of coverage must be selected, and the total premium must be paid, at the time of enrollment. **The** Ross University **Student Health Insurance Policy is not renewable. However, you may re-enroll for the next policy year if you are eligible at that time. All enrollments are final. Once an application has been received, coverage cannot be cancelled and no refunds are available.** Once an election of coverage is made, a later application requesting an increase or a decrease of the initially elected coverage period will not be processed, even if received prior to the deadline.

**DESCRIPTION OF BENEFITS**

The Ross University Continuation Coverage is the same as the 2007-2008 Ross University Student Health Insurance Plan. Please see the Ross University Student Health Insurance Plan Brochure on-line at www.chickering.com. Click on "Find your School" and enter #474883 as your Policy Number for a description of benefits, definitions, limitations and exclusions of the Plan for 2007-2008. For a complete description, please refer to the Master Policy.

Payment will be made as allocated herein for Covered Medical Expenses incurred for each Accident or each Sickness while insured under the Plan, not to exceed an Aggregate Maximum while Continuously Insured of $250,000.

The payment of the balance of any Copays, Deductibles, Coinsurance amounts, any charges beyond the allowed Reasonable Charges and any medical expenses not covered are the responsibility of the Covered Person.

I have carefully read the Ross University Continuation Information and elect to enroll as indicated. I permit Ross University to provide The Chickering Group with my enrollment status for purpose of eligibility under this Plan. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage and my dependent(s) coverage can be made void. I understand that if it is later determined that the student is not eligible, the premium will be refunded, unless a claim has been filed, but the premium is not refundable for reasons other than eligibility. I understand that I am under no obligation to purchase the Continuation Plan.

Signature:_____Date:_____

**PLEASE RETURN THIS FORM TO:**

Chickering Benefit Planning Agency, Inc. P.O. Box 15706, Boston, MA 02215-0014