CONTINUATION ENROLLMENT FORM

Blue Cross Blue Shield Blue Care Network of Michigan
Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2023–2024

UNIVERSITY OF MICHIGAN

INTERNATIONAL STUDENT / SCHOLAR HEALTH INSURANCE PLAN (ISHIP)

Please complete the information on both sides. Print clearly and answer **all** questions thoroughly, then email to the address listed on the next page prior to the enrollment deadline date *(must be received on or before the deadline date)*. Incomplete forms will not be accepted.

For questions about enrollment, contact 855-669-8041 or UMSHPStudentInquiries@bcbsm.com.

STUDENT / SCHOLAR INFORMATION.

STUDENT'S / SCHOLAR'S LAST NAME	STUDENT'S / SCHOLAR'S FIRST NAME		MI
STUDENT'S / SCHOLAR'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)			APT / UNIT #
CITY		STATE	ZIP
STUDENT'S / SCHOLAR'S DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE	STUDENT'S / SCHOLAR'S PHONE NUMBER	STUDENT'S / SCHOLAR'S SCHOOL ID NUMBER
STUDENT'S / SCHOLAR'S EMAIL ADDRESS			OK TO CONTACT YOU VIA EMAIL? ☐ YES ☐ NO
IF YES, WHAT IS YOUR HOME COUNTRY OR COUNTRY OF REGULAR DOMICILE?			

SELECT ENROLLMENT PLAN.

The International Student or International Visiting Scholar may be eligible to continue coverage for a period not the exceed a maximum of three (3) months. The maximum length of the continuation shall be determined by the date your coverage ends under the F-1 or J-1 status.

F-1 / J1 Coverage End	Continuation Option Select the Number of Months	Maximum Continuation Coverage End Date	Enrollment Deadline
09/30/2023	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	12/31/2023	10/31/2023
10/31/2023	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	01/31/2024	11/30/2023
11/30/2023	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	02/29/2024	12/31/2023
12/31/2023	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	03/31/2024	01/31/2024
01/31/2024	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	04/30/2024	02/29/2024
02/29/2024	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	05/31/2024	03/31/2024
03/31/2024	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	06/30/2024	04/30/2024
04/30/2024	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	07/31/2024	05/31/2024
05/31/2024	☐ 1 Mo. ☐ 2 Mos. ☐ 3 Mos.	08/31/2024	06/30/2024
06/30/2024	☐ 1 Mo. ☐ 2 Mos.	08/31/2024	07/31/2024
07/31/2024	☐ 1 Mo.	08/31/2024	08/31/2024

Number of Months	Student / Scholar Only	Student / Scholar + 1 Dependent	Student / Scholar + 2 or More Dependents
☐ 1 Mo.	☐ $ 203.67	☐ $ 407.34	☐ $ 611.01
☐ 2 Mos.	☐ $ 407.34	☐ $ 814.68	☐ $ 1222.02
☐ 3 Mos.	☐ $ 611.01	☐ $ 1222.02	☐ $ 1833.03
TOTAL AMOUNT DUE	= $ 0	= $ 0	= $ 0

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DEPENDENT INFORMATION, IF APPLICABLE.
Dependents must be enrolled on the date the student / scholar enrolls.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH
SPOUSE / DOMESTIC PARTNER				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE

NOTICE TO STUDENT / SCHOLAR (SIGNATURE REQUIRED)
Once an International Student or International Visiting Scholar's status as a University of Michigan F-1 or J-1 visa holder ends, the International Student or International Visiting Scholar may be eligible to continue coverage in this Plan for a period not to exceed a maximum of three months. The length of the continuation shall be determined by the date your coverage ends under the F-1 or J-1 status with the University (as reported to BCN), not to exceed the normal Policy termination date, and must be purchased in three (3) month intervals, or the lesser thereof based on the F-1/J-1 end date.

To be eligible for Continuation, you must have been enrolled under the University of Michigan International Student/ Scholar Health Plan prior to the start of the Continuation. International Students or International Visiting Scholars may also cover eligible Dependents under this provision. Coverage for Dependents shall be for the same period as the student / scholar, and the Dependents must have been covered under the Plan prior to the Continuation start date. Enrollment in the Continuation Coverage must be completed by the end of the month in which your eligibility under this provision begins.

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit the University of Michigan to provide Blue Water Benefit Administrators with enrollment status for purposes of eligibility under this plan.** I warrant that the information I have provided on this form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse / domestic partner, and child(ren), can be made void. I understand that if it is later determined that I am not eligible (see the Plan Certificate for eligibility guidelines), the premium will be refunded, minus any claims paid, but the premium is not refundable for reasons other than eligibility.

DO WE HAVE YOUR PERMISSION TO COMMUNICATE ELECTRONICALLY WITH YOU REGARDING THIS ENROLLMENT FORM AND THIS STUDENT / SCHOLAR HEALTH INSURANCE PLAN? ☐ YES ☐ NO

* **Enrollment Guidelines:** For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Enrollment Forms received after the deadline will not be accepted.

REMIT PAYMENT IN U.S. FUNDS ONLY.
Please complete credit card information.

Credit card authorization charge will appear as "Student Health Insurance, Blue Water" on the credit card statement.

CREDIT CARD #																EXPIRES (MM / YY)	CSV CODE
NAME OF CARDHOLDER (PLEASE PRINT)																CHARGE AMOUNT: $	
CARDHOLDER'S BILLING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)																APT / UNIT #	
CITY												STATE		ZIP		COUNTRY	

CONTINUATION ENROLLMENT FORM (CONTINUED)

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By signing below, I authorize my credit card to be charged the amount listed above for the coverage selected under the University of Michigan International Student / Scholar Health Insurance Plan.

I ACCEPT THE FOLLOWING CANCELLATION / REFUND POLICY.
There are no premium refunds, except when the Plan participant leaves school and permanently returns to his or her home country, or enters the armed forces of any country, and there are no claims on file. A refund request must be sent in writing to UMSHPStudentInquiries@bcbsm.comwith reason for cancellation. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to approval of Blue Water Benefit Administrators and / or the insurance company.

CARDHOLDER SIGNATURE _____ **DATE**_____

I CERTIFY THAT I WAS ENROLLED UNDER THE UNIVERSITY OF MICHIGAN INTERNATIONAL STUDENT/SCHOLAR HEALTH PLAN PRIOR TO THE START OF THE CONTINUATION PLAN.

STUDENT / SCHOLAR SIGNATURE_____ **DATE**_____

RETURN THIS FORM WITH PAYMENT TO UMSHPStudentInquiries@bcbsm.com

MUST BE RECEVIED BY THE APPLICABLE DEADLINE DATE.

If there are any discrepancies between this document and the Certificate, the Certificate will govern.