

CU GME HEALTH BENEFITS PLAN  
2009-2010 MEDICAL INSURANCE EXTENSION

NAME \_\_\_\_\_

(FORWARDING) ADDRESS \_\_\_\_\_  
\_\_\_\_\_

PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

Reason for extension request:  GME TERMINATION Termination date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

LEAVE OF ABSENCE Start date of self-pay: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To enroll in the Extension Plan:

1. Complete and sign this form.
2. Complete and sign the enclosed Extension Enrollment/Claim Form.
3. **Send both forms and a check or money order for the first month's coverage to CU GME Extension c/o AmeriBen; P.O. Box 7565; Boise, ID 83707. This must be postmarked no later than your last day in the program. (If you received your extension notice after your termination date, your payment must be postmarked no later than 20 days after the date your extension notice was mailed to you). Late payment cannot be accepted.**

	Thru June 30, 2008	July 1, 2009 – June 30, 2010 Coverage beginning 7/1/2009:	Comments
<b>Monthly Premium</b>	\$720.00	<b>\$780.00</b>	Single or Family – Composite rate
<b>½ Monthly Premium</b>	\$360.00	<b>\$390.00</b>	<u>Only</u> for month during which termination occurs, and only for termination dates from 14 <sup>th</sup> through 21 <sup>st</sup> of the month.
<b>Weekly Premium</b>	\$180.00	<b>\$195.00</b>	<u>Only</u> for month during which termination occurs, and only for termination dates from 22 <sup>nd</sup> through end of month.

You must pay for a full month's coverage except as stated above. No partial payments are accepted nor any refunds issued. (The only time a refund will be provided is if the extension participant becomes eligible for other group insurance coverage, and notifies the Claims Administrator by the 20<sup>th</sup> calendar day of the month for which the refund is requested.) No refunds for partial month coverage are permitted.

This extension is for the **medical plan only** (*does not include dental, life or disability insurance*) and is subject to plan provisions in effect at the time services are rendered. Eligible plan members or eligible dependents may purchase extended coverage for a **maximum of 15 consecutive months**. *The extension will end on the earlier of: 1) expiration of the 15 consecutive month period, or 2) the date the individual becomes covered (as an employee or dependent) or eligible for coverage under any other group plan or Medicare, unless the plan has an exclusion or limitation that applies to the individual with respect to a pre-existing condition, (This provision does not apply when the member is on a qualified USERRA Military Leave of Absence), or 3) the last day of the last month for which premium was paid on time.*

You, or any member of your family who is covered under any other group plan, **or is eligible to enroll in such a plan**, may **not** enroll in the extension coverage, unless the plan has an exclusion or limitation that applies to the individual with respect to a pre-existing condition.

In order to maintain your coverage, **additional monthly payments must be postmarked by the 5th of the month for which coverage is intended**. If the 5th falls on a weekend or holiday, then the date is extended to the following business day. A fully completed and signed Notice of Premium Due form **must accompany** each check.

**If payment is not postmarked as above, including the fully completed and signed Notice of Premium Due form, your check will be returned; and your insurance will be terminated effective the last day of the last month in which premium was paid on time. NON-PAYMENT, OR LATE PAYMENT, WILL BE CONSIDERED CANCELANATION OF THIS COVERAGE, AND BENEFITS WILL NOT BE REINSTATED.**

**IMPORTANT: PLEASE COMPLETE**

- I intend to make further payments for this coverage. Please send me Notice of Premium Due forms.
- I do not intend to make any further payments for this coverage. Please terminate my coverage at the end of the period for which I have paid premium.

*YOUR SIGNATURE ACKNOWLEDGES THAT YOU WISH TO ENROLL IN THE CU GME HEALTH INSURANCE EXTENSION AND THAT YOU UNDERSTAND THE CONDITIONS FOR CONTINUED COVERAGE.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MAKE CHECKS PAYABLE TO: CU GME EXTENSION PLAN**  
**MAIL PAYMENTS TO: CU GME EXTENSION**  
C/O AMERIBEN  
P.O. BOX 7565  
BOISE, ID 83707

**Extension Coverage Questions: 1-866-955-1498**

**2009-2010 CU GME EXTENSION Enrollment & Claim Form**  
 Form must be completely filled out, signed and returned with initial premium payment.

**Resident**

<b>Name:</b> _____ Last First Middle Initial <b>Social Security #:</b> _____ <b>Date of Birth:</b> _____ <b>Street Address:</b> _____ <b>City, State, Zip:</b> _____ <b>Home Phone:</b> _____ <b>Day/Cell Phone:</b> _____	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Marital Status:</b> Do <b>not</b> request coverage for a "future" dependent on this form. <input type="checkbox"/> Single <input type="checkbox"/> Married Date of Marriage: _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated Date of Divorce or Separation: _____ <input type="checkbox"/> Same gender domestic partnership (SGDP) Complete "spouse" information for SGDP only if requesting coverage. See add'l forms on web.
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**Spouse - Please complete even if not requesting coverage for spouse.**

<b>Full Name of Spouse/SGDP:</b> _____ Last First Middle Initial <b>Social Security #:</b> _____ <b>Date of Birth:</b> _____ <b>Is Spouse Employed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, name of Employer</b> _____ <b>Does your spouse have other medical insurance or access to other medical insurance through his/her employer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
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**Dependent Children**

Last Name	First Name	Date of Birth	Sex	Relationship*	Coverage Requested		Full-Time Student		Employed		Other Insurance Coverage							
					Yes	No	Yes	No	Yes	No	Medical							
											Yes	No						

\*Relationship: Son, daughter, step-child, or specify other relationship

**Other Insurance Coverage**

**If you have answered "yes" to any of the "Other Insurance Coverage" questions above, please complete the following:**

**Medical:** Name of Individual Carrying Policy: \_\_\_\_\_  
 Name of Insurance Company: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**All benefits are subject to the provisions of the Plan Document, posted at [www.medschool.ucdenver.edu/gme](http://www.medschool.ucdenver.edu/gme).**

**SIGNATURES:**

The Plan is committed to protecting the privacy of your protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act (HIPAA), or as required or permitted by law. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for healthcare and healthcare operations. You received a copy of the Plan's *Notice of Privacy Practices* as an active member. It explains our privacy practices in detail. If you would like to review this *Notice*, a copy is posted on the website. A printed copy is available from the GME office upon request.

**Your signature below acknowledges receipt of our *Notice of Privacy Practices*, and verifies the following:**

- 1) I/We acknowledge it is the member's/participant's responsibility to know the terms of this insurance coverage.
- 2) I/We certify that the above information is true and correct, and authorize those persons or institutions providing care, treatment, consultation, drugs, or supplies to furnish full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered, including copies of their records.
- 3) I/We authorize any insurance carrier, service plan, union or trust fund or employer to furnish information regarding benefits which I/we may be entitled to and authorize release of any information relevant to a determination of the applicability or implementation of Coordination of Benefits provisions.
- 4) I/We understand that if any benefits are paid under the Plan for a condition or injury which is reimbursed to the member/participant by a third party, the Plan is entitled to a refund of such benefits to the extent such expenses are reimbursed for the same condition/injury/occurrence.
- 5) I/We authorize direct payment to providers or institutions for medical benefits, when they have submitted a claim on behalf of an eligible family member. A photocopy of this authorization shall be considered as effective and valid as the original.
- 6) I hereby request enrollment for medical care coverage for which I may be eligible with the University of Colorado Denver School of Medicine CU GME Extension Plan. I understand that such coverage is provided through a self-funded stop loss program in lieu of an insurance plan and through an agreement between the University and Plan participants, not through an insurance carrier.

**Signature of Resident:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Signature of Spouse:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_