

**CONTINUATION FORM – PROOF OF GRADUATION REQUIRED**

**UNIVERSITY OF HOUSTON**

**Continuation Option following Loss of Eligibility under the Student Health Insurance Plan Due to Graduation**

**2008/2009 Policy Year**

Underwritten by "National Union Fire Insurance Company of Pittsburgh, Pa.,  
with its principal place of business in New York, NY"

Please Check One:

Main AMH9073449

Clear Lake AMH9073389

Victoria AMH9073469

Downtown AMH9073429

**Complete this form in its entirety**

Student Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_ PeopleSoft ID Number \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Email Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

*"I have read the brochure regarding the Student Health Insurance Plan, including the Notice of the Right of Continuation, and elect to continue coverage as shown below."*

Signature of Student: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS COMPLETED FORM, PROOF OF GRADUATION AND APPLICABLE PREMIUM MUST BE RECEIVED IN MACORI'S OFFICE WITHIN 31 DAYS IMMEDIATELY FOLLOWING YOUR TERMINATION DATE.**

Premium for Basic Coverage		
Check One	Coverage Period	Premium Amount
<input type="checkbox"/>	Student Only-30 days following termination date of coverage	\$ 74.00
<input type="checkbox"/>	Student Only-60 days following termination date of coverage	\$148.00
<input type="checkbox"/>	Student Only-90 days following termination date of coverage	\$222.00
<input type="checkbox"/>	Student Only-120 days following termination date of coverage	\$296.00
<input type="checkbox"/>	Student Only-150 days following termination date of coverage	\$370.00
<input type="checkbox"/>	Student Only-180 days following termination date of coverage	\$444.00

Mail enrollment form and proof of graduation with check or money order made payable to "National Union Fire Insurance Company of Pittsburgh, Pa." to: Macori, P.O. Box 2478, Spring, Texas 77383-2478.

**Complete the following if paying by Visa or MasterCard and mail to the above address:**

Charge Card Authorization;  Visa  MasterCard

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Please charge this amount: \_\_\_\_\_

\_\_\_\_\_  
(Print) Name of Cardholder

\_\_\_\_\_  
Signature of Cardholder

**COVERED PERSON'S ELIGIBILITY CEASES ON THE EARLIEST OF THE FOLLOWING: (A) The Covered Person has met the Maximum Policy Benefit under the Student Health Insurance Plan; or (B) The Termination Date of Coverage purchased.**