

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DISTANCE EDUCATION STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

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**UNIVERSITY OF ALASKA ANCHORAGE / ALASKA SOUTHEAST /
UNIVERSITY OF ALASKA FAIRBANKS**

2011-248-1
2011-335-1

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
		MIDDLE INITIAL:	
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH YEAR
PERMANENT ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

DEPENDENT INFORMATION: Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: _____

DATE: _____

CAMPUS LOCATION:

- UNIVERSITY OF ALASKA ANCHORAGE
- UNIVERSITY OF ALASKA SOUTHEAST
- UNIVERSITY OF ALASKA FAIRBANKS

Optional Major Medical coverage may only be purchased simultaneously and in conjunction with the purchase of basic coverage at the time of initial enrollment in the Plan. Students may purchase optional coverage for themselves or for themselves and all family members.

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES
UNIVERSITY OF ALASKA ANCHORAGE/SOUTHEAST
2011-248-1

INSURED CATEGORY: Distance Education

PERIOD CODES		Annual (A-)
ID CODES		
M	Student	<input type="checkbox"/> \$ 1747.00
N	Spouse	<input type="checkbox"/> \$ 6145.00
O	Each Child	<input type="checkbox"/> \$ 2634.00
P	All Children	<input type="checkbox"/> \$ 6056.00
		Quarterly (QX)
Cannot be purchased after 05/15/2012		
M	Student	<input type="checkbox"/> \$ 437.00
N	Spouse	<input type="checkbox"/> \$ 1536.00
O	Each Child	<input type="checkbox"/> \$ 659.00
P	All Children	<input type="checkbox"/> \$ 1514.00
Optional Major Medical		
Q	Student	<input type="checkbox"/> \$ 527.00
R	Spouse	<input type="checkbox"/> \$ 527.00
S	Each Child	<input type="checkbox"/> \$ 527.00
T	All Children	<input type="checkbox"/> \$ 1213.00

PLEASE CHECK ALL APPROPRIATE BOXES
UNIVERSITY OF ALASKA FAIRBANKS
2011-335-1

INSURED CATEGORY: Distance Education

PERIOD CODES		Annual (A-)
ID CODES		
I	Student	<input type="checkbox"/> \$ 1663.00
J	Spouse	<input type="checkbox"/> \$ 5840.00
K	Each Child	<input type="checkbox"/> \$ 2501.00
L	All Children	<input type="checkbox"/> \$ 5755.00
		Quarterly (QX)
Cannot be purchased after 05/25/2012		
I	Student	<input type="checkbox"/> \$ 416.00
J	Spouse	<input type="checkbox"/> \$ 1460.00
K	Each Child	<input type="checkbox"/> \$ 625.00
L	All Children	<input type="checkbox"/> \$ 1439.00
Optional Major Medical		
M	Student	<input type="checkbox"/> \$ 524.00
N	Spouse	<input type="checkbox"/> \$ 524.00
O	Each Child	<input type="checkbox"/> \$ 524.00
P	All Children	<input type="checkbox"/> \$ 1207.00

UAA/UAS EFFECTIVE / EXPIRATION PERIODS:

Annual 08-15-2011 to 08-14-2012
Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.
 Quarterly coverage expires 3 months following receipt of your premium or August 14, 2012, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received.
Requested Effective Date: ____ / ____ / ____

UAF EFFECTIVE / EXPIRATION PERIODS:

Annual 08-25-2011 to 08-24-2012
Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.
 Quarterly coverage expires 3 months following receipt of your premium or August 24, 2012, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received.
Requested Effective Date: ____ / ____ / ____

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment card along with premium payment to:
 UnitedHealthcare **StudentResources**
 PO Box 809026
 Dallas, TX 75380-9026.
 Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

To enroll online: If you would like to use a credit card to enroll, please go to www.uhcsr.com, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then select the Enroll Now link to enroll online.