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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
AMERICAN STUDENT DENTAL ASSOCIATION

Not Available to Residents of MA, NH, NJ, NY, NC, OR, PR, VT, WA

2012-227-1

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:		OR STUDENT ID #:
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ ________ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _______ / _______ MONTH YEAR
PERMANENT [U.S.] 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: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ ________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ ________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ ________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ ________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ 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 and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

Notice Regarding Illinois' Religious Freedom Protection and Civil Union Act: Effective June 1, 2011, the state of Illinois passed the Religious Freedom Protection and Civil Union Act, which allows couples of the same or opposite sex to enter into a Civil Union. Civil Union couples and married couples are to be treated identically and provided the same protections and benefits under Illinois law.

STUDENT'S SIGNATURE: ______________________________________ DATE: ______________________

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CAMPUS/SCHOOL ATTENDING: ______________________________

Please Print Name of College or University Must be completed in order for application to be processed.

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

PLEASE CHECK ALL APPROPRIATE BOXES

2012-227-1

INSURED CATEGORY: ❑ All	Annual (A-)	9 Months (Z9)	6 Months (Z6)	3 Months (Z3)
PERIOD CODES / ID CODES	Cannot be purchased after 08-31-2012	Cannot be purchased after 10-31-2012	Cannot be purchased after 01-31-2013	Cannot be purchased after 04-30-2013
1 ❑ Student	❑ $ 1,695	❑ $ 1,296	❑ $ 864	❑ $ 432
2 ❑ Spouse	❑ $ 4,237	❑ $ 3,238	❑ $ 2,159	❑ $ 1,079
3 ❑ All Children	❑ $ 2,966	❑ $ 2,267	❑ $ 1,511	❑ $ 756

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Annual coverage expires 1 year following receipt of your premium or July 31, 2013, whichever is earlier. Nine months coverage expires 9 months following receipt of your premium or July 31, 2013 whichever is earlier. Six month coverage expires 6 months following receipt of your premium or July 31, 2013 whichever is earlier. Three month coverage expires 3 months following receipt of your premium or July 31, 2013, whichever is earlier.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:

UnitedHealthcare **Student**Resources
PO Box 809026
Dallas, TX 75380-9026.

Your cancelled check 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/asda, 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.