**UNIVERSITY OF CHICAGO** **UNITEDHEALTHCARE INSURANCE COMPANY**
**CONTINUATION PLAN ENROLLMENT CARD** **2012-451-1**
**(PLEASE PRINT)**

Student's Name _____/_____/_____
❑ Male ❑ Female Last First MI

Permanent US Address _____
Street or PO Box City State Zip

Social Security #_____Date of Birth_____Phone # (_____)_____

Expected Graduation Date: Month_____ Date_____ E-Mail address_____

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under the Plan and cannot exceed coverage purchased by the student.

| | Last Name | First Name | MI | Date of Birth | Social Security # |
|---|---|---|---|---|---|
| Spouse/Domestic Partner: | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| Child: | | | | | |

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. It is the student's responsibility for timely renewal payments. By signing below, 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; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.

**Signature of Student_____Date_____**

CONT-02-NRL2

**PLEASE CHECK ALL APPROPRIATE BOXES:** **2012-451-1**

**ELIGIBILITY:** All Insured Persons who have been continuously insured under the school's regular student policy for at least 6 consecutive months and who no longer meet the Eligibility requirements under the school's student Policy and who are not eligible for other insurance coverage including Medicare are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at such time of such continuation.

**Insured Category: CONTINUATION**

| **Check the Appropriate Box(es)** | **Monthly (MX)** |
|---|---|
| 8. Student | ❑ $ 332.00 |
| 9. Spouse/Domestic Partner | ❑ $ 585.00 |
| 10. Each Children | ❑ $ 538.00 |
| 11. All Dependents | ❑ $1,090.00 |
| **Seminary:** | |
| 12. Seminary Student | ❑ $585.00 |
| 13. Spouse/Domestic Partner | ❑ $585.00 |
| 14. All Children | ❑ $585.00 |

***To Calculate Your Rate:***
Rate x # of months eligible = Amount Due
Example: $332.00 x 3 months - $996.00

**CALCULATION FOR MONTHLY PREMIUM**

| | |
|---|---|
| MONTHLY RATE (ABOVE) | **$** _____ |
| MULTIPLY BY # OF MONTHS TO PURCHASE | **X** _____ |
| TOTAL PREMIUM ENCLOSED | **$** _____ |

**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. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**