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**FRONTIERMEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE**
**ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION**
**FOR STUDENTS AND THEIR DEPENDENTS**
## ABRAHAM BALDWIN AGRICULTURAL COLLEGE

**2013-566-1**

**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: | |
| HOME COUNTRY: | HOST COUNTRY: | |
| REQUESTED PROGRAM START DATE: | HOST INSTITUTION/CENTER NAME: | |
| HOST INSTITUTION/CENTER ADDRESS: | | |
| EMERGENCY CONTACT: | RELATIONSHIP: | PHONE #: |

**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: |

STUDENT'S SIGNATURE: _____ DATE: _____

## ABRAHAM BALDWIN AGRICULTURAL COLLEGE 2013-566-1

**CAMPUS/SCHOOL ATTENDING:** _____

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

**NOTE:** Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations. All Global Emergency Services must be arranged and provided by Frontier MEDEX, any services not arranged by Frontier MEDEX will not be considered for payment.

**PLEASE CHECK ALL APPROPRIATE BOXES**

**INSURED CATEGORY:** ❑ Standalone Repatriation/Medical Evacuation

| **PERIOD CODES** | Annual (A-) | Fall (F-) | Spring/Summer (J-) |
|---|---|---|---|
| **ID CODES** | | | |
| 21 Student | ❑ $ 55.00 | ❑ $ 25.00 | ❑ $ 30.00 |
| 22 Spouse | ❑ $ 55.00 | ❑ $ 25.00 | ❑ $ 30.00 |
| 23 Each Child | ❑ $ 55.00 | ❑ $ 25.00 | ❑ $ 30.00 |

NOTICE: Frontier MEDEX will be effective the date the correct amount due is received by UnitedHealthcare **Student**Resources or the Effective Date of the coverage period, whichever is later.

**PLEASE CHECK ALL APPROPRIATE BOXES**

**EFFECTIVE / EXPIRATION PERIODS:**

| | |
|---|---|
| Annual | ❑ 08-01-2013 to 07-31-2014 |
| Fall | ❑ 08-01-2013 to 12-31-2013 |
| Spring /Summer | ❑ 01-01-2014 to 07-31-2014 |

**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 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.