

**FRONTIERMEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE
ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION
FOR STUDENTS AND THEIR DEPENDENTS
UNIVERSITY OF NORTH GEORGIA**

PROCESSOR STAMP DATE RECEIVED HERE

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2013-593-1

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 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: <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:

STUDENT'S SIGNATURE: _____

DATE: _____

CAMPUS/SCHOOL ATTENDING: _____

Please Print Name of University. 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	<input type="checkbox"/> \$ 55.00	<input type="checkbox"/> \$ 25.00	<input type="checkbox"/> \$ 30.00
22 Spouse	<input type="checkbox"/> \$ 55.00	<input type="checkbox"/> \$ 25.00	<input type="checkbox"/> \$ 30.00
23 Each Child	<input type="checkbox"/> \$ 55.00	<input type="checkbox"/> \$ 25.00	<input type="checkbox"/> \$ 30.00

NOTICE: Frontier MEDEX will be effective the date the correct amount due is received by UnitedHealthcare **StudentResources** 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 **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.