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FRONTIERMEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE
ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION
FOR STUDENTS AND THEIR DEPENDENTS

KENNESAW STATE UNIVERSITY

2013-599-1

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: ____________________

KENNESAW STATE UNIVERSITY 2013-599-1

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	❑ $ 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.